

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Form 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the Bureau of Health service. Then please remove carbon paper. Pages 1 and 2 should be filed in 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 6 0 8 / 11

REG. NO.

1. FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR						2b HOUR			
1. DECEASED NAME FIRST MIDDLE LAST			July 10 1903 03 23 86						5:26p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS MONTHS DAYS HOURS MIN.						
7a BIRTHPLACE Lebanon		7b CITIZEN OF WHAT COUNTRY? USA		7c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		82 YRS						
10 CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.						
13a STATE Mass.			13b CITY OR TOWN Worchester			12a USUAL OCCUPATION Housewife						
FATHER'S NAME Peter			LAST Hajj			12b KIND OF BUSINESS OR INDUSTRY						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b SOCIAL SECURITY NO. 024 32 2596			17. INFORMANT 9800 Hillridge Dr. Hajj George Abdow (Son) Kensington, Md.						
PART I. DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			b) CONGESTIVE HEART FAILURE			4 YEARS						
			DUE TO, OR AS A CONSEQUENCE OF ANGIOFIBROSIS									
			DUE TO, OR AS A CONSEQUENCE OF									
			(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 31/4 19 86 to 31/23 19 86, that (I) (we) last saw the deceased alive on 31/23 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ADDRESS						31/23/86			
P. Wisotsky, M.D.			6188 Oxon Hill Rd, Oxon Hill MD 20745									
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		3/26/86		Hope Cemetery		Worchester, Mass.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi S.S.Md.						MAR 26 1986			Julia L. Rinaldi			

1110-0

DEPARTMENT OF STATE

RECEIVED



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGES 4 & 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER REMITTANT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO FUNERAL CREMATION OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08/12					
1- STATE REGISTRAR			I DECEASED NAME FIRST MIDDLE LAST									2a. DATE KNOWN OF DEATH MATED	2b. HOUR				
5			James E. Abrams									3-17 1986	M				
99			3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	7c. DATE PRONOUNCED DEAD	2d. MONTH DAY YEAR	2e. 24 HOUR		
			4. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's						
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Forearm					
11. STATE M.D.			12. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Prince George's Upper Marl.			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS 15209 Peerless Avenue 20772			12b. KIND OF BUSINESS OR INDUSTRY P.G. County Schools Board					
14. FATHER'S NAME FIRST Milton			15. MOTHER'S MAIDEN NAME FIRST Ethel			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 218-34-7443			17. INFORMANT Shirley M. Curtis			ADDRESS 15209 Peerless Avenue Upper Marlboro, MD 20772		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ischaemic cerebrovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Fracture mittelliesse</i>																	
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>			TITLE (SPECIFY) Deputy M.D.			EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct, Temple Hills, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/22/86			23c. NAME OF CEMETERY OR CREMATORIAL Moses Cemetery			23d. LOCATION CITY OR TOWN Anne Arundel County, Maryland			DATE SIGNED 3-18-86					
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.			4339 HUNT PLACE, N.E.			25a. DATE REC'D. BY REGISTRAR MAR 24 1986			25b. REGISTRAR'S SIGNATURE <i>J. L. Davidson</i>								
DHMH - 17 (VR A15 ME (5))			WASHINGTON, D.C. 20019														

DEPT. OF  
EDUCATION  
1960

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 0 8 / 1 3  
6 00AM M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME <b>FIRST</b> EVA <b>MIDDLE</b> G. <b>LAST</b> ALLEN			2. DATE OF DEATH MONTH 3 DAY 5 YEAR 86	3. HOUR 6 00AM M
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH NOVEMBER DAY 7 YEAR 1892	6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDIANA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE COUNTY</b> MD.
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>PRINCE GEORGE GENERAL HOSPITAL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>BETHESDA</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <b>FIRST</b> EUGENE <b>MIDDLE</b> EDWARD <b>LAST</b> KROG			15. MOTHER'S MAIDEN NAME <b>JESSIE</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>406-34-2089</b>	17. INFORMANT <b>BARBARA A. MCNEES DAUGHTER SAME AS 13</b>	18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOURS</b>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MESENTERIC ISCHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC HEART + VASCULAR DISEASE</b> <b>YEARS</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 1984	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3/5/86	
22a. I certify that (I) (we) attended the deceased from <b>1984</b> to <b>1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. (I) (we) did not view the body after death.				
22b. SIGNATURE <b>P. Schissler MD</b>				
22c. DEGREE				
22d. ADDRESS <b>7500 Greenway Cir Dr Greenbelt MD 20770</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>MAR 6, 1986</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>METROPOLITAN CREMATORY ALEXANDRIA</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>VIRGINIA</b>
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS, JR.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John F. ...</b>
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.				

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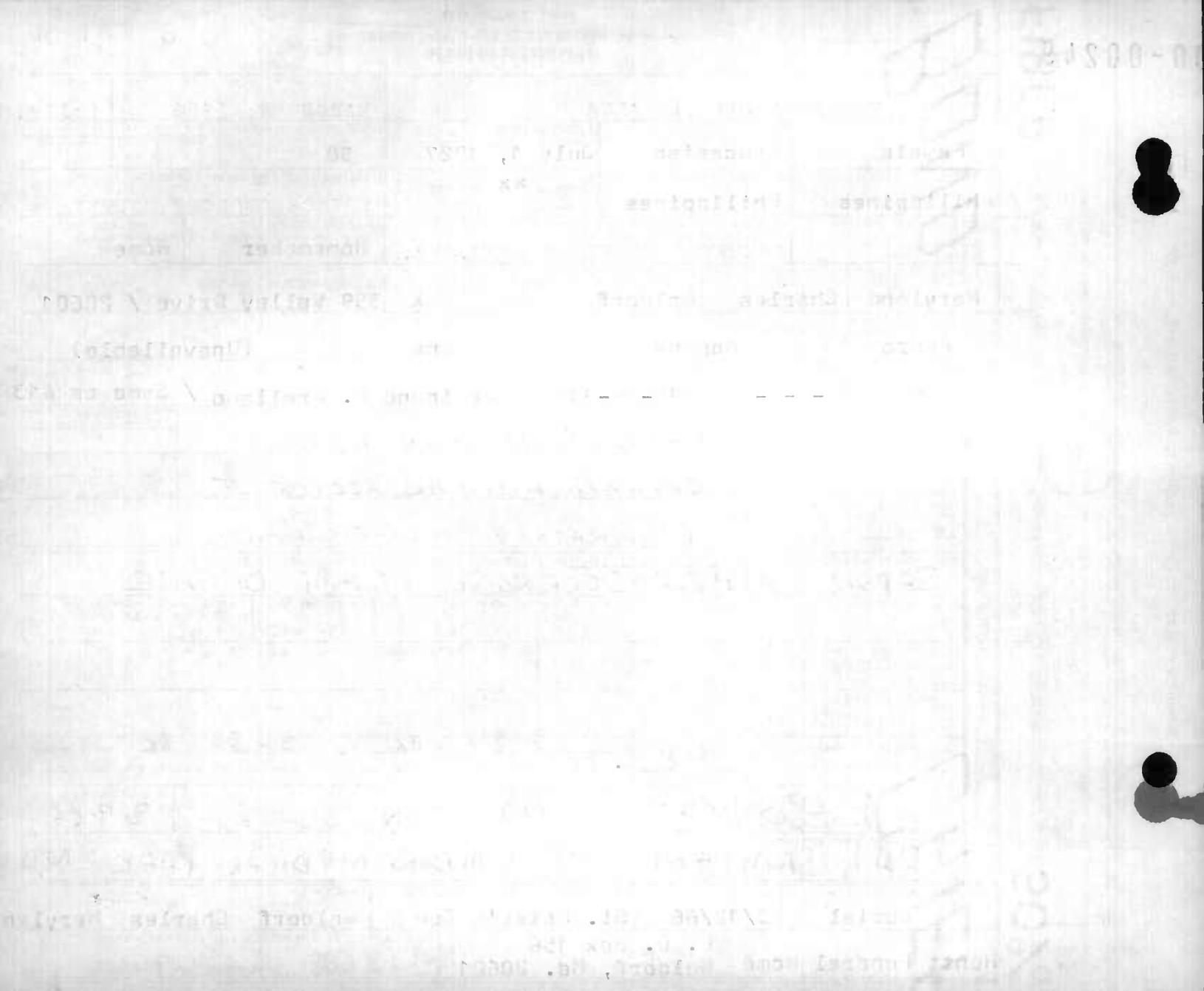
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then place handle copy in pocket. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as Item 18 above, mark it again.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MARCH 8, 1986			8:11 P.M.						
FERNANDA MAPAYE ALVA															
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR						
Female			Caucasian	MONTH	DAY	YEAR	MONTHS	YEARS	MONTHS	YEARS	IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Philippines			Philippines		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			PRINCE GEORGES COUNTY MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												
CLINTON			SOUTHERN MARYLAND HOSP. CTR.												
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 359 Valley Drive / 20601					
14. FATHER'S NAME			FIRST Pedro	MIDDLE Mapaye	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 212-04-1105			17. INFORMANT			Ferdinand M. Arellano / Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST															
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT															
DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY INSUFFICIENCY.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION			19b. SEPSIS. ATHEROSCLEROTIC HEART DISEASE			19c. DATE OF OPERATION			19d. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
												YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
21f. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from 1-31-1986 to 3-8-1986, that (II) (we) last saw the deceased alive on 3-8-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 3-9-86			
22b. SIGNATURE <i>R. B. Samtani</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) RAJ. SAMTANI MD.			22f. ADDRESS WALDORF MEDICAL PARK. MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 3/12/86		23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cem		23d. LOCATION CITY OR TOWN Waldorf			23e. COUNTY Charles	23f. STATE Maryland				
24. FUNERAL DIRECTOR NAME Huntt Funeral Home			ADDRESS P. O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR MAR 12 1986			25b. REGISTRAR'S SIGNATURE <i>Jeanne Anderson Pendleton</i>							

2180-0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item B shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608715					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR			
Albert			LEO	Ammann	Jr.	March 31, 1986						5:50A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male		caucasian		Oct. 18th 1900		85			MONTHS	DAYS	HOURS	MIN.			
YRS.		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Ohio		USA						Prince Georges County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel		Greater Laurel Beltsville Hospital Retired										Parts Expiditer			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Md.		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		800 Kay Ct. #205		20707					
Prince George Laurel															
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE			LAST				
Albert		L.		Ammann Sr.	Rose						Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		-----		218-10-4375		Thelma J. Ammann		same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Acute Renal Failure												2 days			
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cerebral Hemorrhage and Hypotension												2 weeks			
DUE TO, OR AS A CONSEQUENCE OF (c) Possibly Obstructive Glaucoma												2 weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
Arteriosclerotic Cardiovascular Disease															
19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. AUTOPSY?		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)											
		P.M. 19													
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> IN OFFICE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from approximately 19 79 to 3/31 19 86, that (I) (we) last saw the deceased alive on 3/29 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Dennis R. Schaefer MD										3/31/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
Dennis R. Schaefer MD		1420 Laurel Park Dr. #102 Laurel Md 20707													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial		4/2/86		IVY HILL Cemetery		Laurel		P.G.		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Fleck F.H. Inc.		7601 SANDY SPR. RD. LAUREL MD.		APR 01 1986		John Wilson Pendell									

21310-00

ANGELA

WALKER

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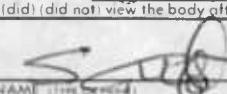
00-00347

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 1 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR	
ELLIOTT D.					ARNETT	03-11-86				2.00PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		Black		Feb. 8, 1910		76		MONTHS DAYS		HOURS MIN.	
YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
D.C.		U.S.A.				PRINCE GEORGE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY		PRINCE GEORGE GENERAL HOSPITAL		Retired		Vets. Admin.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		20781	
Md.		P.G.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3215 Kenilworth Ave.			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS		Lee		LAST
		Charles	G.	Arnett	Sannie		3211 52nd Ave.,				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		17. ADDRESS		Charles L. Arnett-Hyattsville, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes		WW II		577-22-9958							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Respiratory Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>antr. aspiration pneumonia</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-11-86</u> , 19 <u>86</u> , to <u>3-11</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5-11-86</u> , 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		22c. DATE SIGNED <u>3/13/86</u>									
22d. PHYSICIAN'S NAME (IF APPLICABLE) DR. SURESH C. GUPTA		22e. ADDRESS 3503 PERRY ST., MOUNT RAINIER, MD. 20822									
23a. BURIAL/CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>3/14/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN LANDOVER P.G. MD.		23e. COUNTY		STATE	
24. FUNERAL DIRECTOR NAME H. S. (WASHINGTON & SONS 4925 BURROUGHS AVE.)		ADDRESS N.C.		25a. DATE REC'D. BY REGISTRAR MAR 14 1986		25b. REGISTRAR'S SIGNATURE Sister Leidson Pendleton					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows injury, or other traumatic event, the medical



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 7 1 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Rozella Artis</i>						March 25, 1986			140/A M		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
Female		Black	MONTH 06	DAY 06	YEAR 08	77				MONTHS YRS.	IF UNDER 24 HRS
7b. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		USA				P.G.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
		<i>at home</i>			Domestic			20743			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		PG	Capt. Hgts.			6815 Pepper Street					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST Henry Gray		MIDDLE	LAST	FIRST Mattie Whittington			MIDDLE	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
(If yes, give war or dates)		579 44 0464			Shirley V. Scott-daughter-7900			Darcy			
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)			Gangrene foot with sepsis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			DUE TO, OR AS A CONSEQUENCE OF (b) vascular insufficiency - legs			years			
					DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Chronic Brain Syndrome</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
71a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
72a. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE
22a. I certify that (this hospital) attended the deceased from now the deceased alive on <i>3/25/86</i> , and that (my) our opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.											
72b. SIGNATURE <i>J. R. Gladue</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3/25/86</i>			
73e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. R. Gladue</i>		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial		<i>March 29</i>	1986 Lincoln Memorial Cemetery								
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
John Stewart		MAR 31 1986			<i>Julia Davidson-Pender</i>						
Stewart Funeral Home-4001 Benn. Rd., N.E.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for seal on the burial or cremation permit. Then please execute original death certificate. Pages 1 and 2 should be filled in with 22 hours of death. Item 21 is marked as having been filled in above.

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00-0187

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 8 / 1 8

1 -  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20 DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
				RITA	m.	AUGUSTERFER	03-23-86				12 :57 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		June 30, 1916		69		YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Washington DC		USA				PRINCE GEORGE'S COUNTY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		Ret. Nurse		Anesthetist		21403				
13a. STATE		14. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE						
MD		AA. Annapolis				1459 Wagga mar Circle						
15. FATHER'S NAME		FIRST	MIDDLE	LAST	16. MOTHER'S MAIDEN NAME							
Raymond				Augusterfer	Frances							
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18. SOCIAL SECURITY NO.		19. INFORMANT		20. ADDRESS		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		517-10-6091		Katherine Ryan-		same as #13						
22. CAUSE OF DEATH: Enter only one cause per line for 1a, 1b and 1c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic tumor</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF: (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-(b) <i>chronic lymphocytic leukemia</i>												
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED				23c. AUTOPSY?		23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		24d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
25a. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>317</i>				25c. LOCATION STREET <i>Po</i> CITY OR TOWN <i>3122</i> COUNTY <i>96</i> STATE <i>6</i>						
26a. I certify that (b) this hospital attended the deceased from <i>1980</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I have (had) no (no) contact with the body after death.												
27a. PHYSICIAN'S NAME, TYPE OR PRINT		27b. DEGREE		27c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27d. DATE SIGNED						
LEWIS DENNIS, M.D.						3/17/86						
28a. BURIAL, CREMATION, REMOVAL (SPECIFY)		28b. DATE		28c. NAME OF CEMETERY OR CREMATORIUM		28d. LOCATION CITY OR TOWN <i>Bladensburg</i> COUNTY <i>P.G.</i> STATE <i>MD</i>						
Burial		Mar. 25 1986		Mt. Olivet								
29a. FUNERAL DIRECTOR NAME		ADDRESS		29b. DATE REC'D. BY REGISTRAR		29c. REGISTRAR'S SIGNATURE						
Taylor Funeral Chapel - Annapolis, MD				MAR 27 1986		<i>Susan Gordon Pendleton</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be searched within 24 hours after death. Page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be directed for use on the burial or cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If item 21 is marked by Item 18 shows any injury, at other traumatic event, the medical examiner will be notified and an investigation will be made.

5581 87-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be forwarded for use in the funeral service. Then please remove carbon copies. Please and attach to the death certificate and mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INFORMATION: If item 21 is marked or that 18 shows any injury, or other traumatic event, the medical examiner

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608719
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
WILFRED			William	BABB		MAR	29	86		0910 P.M.
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			7. IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian	2/2/15			71 YRS.				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		
Wisconsin		USA						MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
ANDREWS AFB		Malcolm Grow Hospital			Air Force			U. S. Govt.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MD	CHARLES	WALDORF						1107 Stone Ct./20601		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
William		Wallace	Babb	Ethel			Margaret	Terry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT Daughter			ADDRESS		
Yes		Korean 254-40-1301			Shirley Coffren			same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any										
(b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 21 MARCH 1986, to 29 MARCH 1986, that (I) (we) last saw the deceased alive on MARCH 29, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3/29/86
22b. SIGNATURE <i>Horace Tsu</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HORACE TSU		22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER AAFB MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/2/86		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION CITY OR TOWN Arlington			STATE VA	
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, MD		ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 02 1986			25b. REGISTRAR'S SIGNATURE J. M. Anderson-Pandell		



4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Please send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical certification will be required.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8608120
				REG. NO.
1. FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR
1. DECEASED NAME (TYPE OR PRINT)	Jack	NMI	BAKER	March 25, 1986
2. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	2d. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HR.
Male	White	May 30, 1922	63 YRS	3:50 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
Wash. D.C.	USA		Prince George's MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (Occupation or kind of working life)
Lanham	Doctors' Hospital of Pr. Geo. Co.			Building Engineer Const. Co.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. STREET ADDRESS / ZIP CODE 15921 Emory Lane 20853	
Md.	Mont.	Rockville	15. MOTHER'S MAIDEN NAME	
14. FATHER'S NAME FIRST	MIDDLE	LAST	FIRST	MIDDLE
Albert	C.	Baker	Mary	Ann
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension, Severe dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anuria, Hemoperitoneum</u>	
Yes	577 20 7515	Richard G. Baker (Son)	Greenbelt, Md.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Fungating carcinoma of colon with liver metastases.</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 3-22, 1986, to 3-25, 1986, that (I) (we) last saw the deceased alive on 3-25-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Rakesh Arora	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAKESH ARORA, M.D.	22e. ADDRESS 14300 Gallant Fx Lane, #22 Bowie, Maryland 20715			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 3/28/86	23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory	23d. LOCATION CITY OR TOWN Wash.D.C.	COUNTY STATE
24. FUNERAL DIRECTOR NAME Hines/Rinaldi	ADDRESS 11800 New Hamp.Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 24 1986	25b. REGISTRAR'S SIGNATURE John Davidson - Jr.
DHMH - 16 60M 7/84 (VRA 15, 4)				

1971-00

The two groups which have  
been described above are the  
central and west groups.  
The eastern and southern groups will be described

28 25-26 28 - 30 27 28 29

2012-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be retained for use as the burial-transit permit. Then please remove carbon papers Part I and II should be retained for 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked item 18 should state injury, or other traumatic event, the medical certifying physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	86 08/21						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
GRACE			I	BANKES		3-13-86				9:55 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Female		Caucasian		Month Day Year April 18, 1902		83							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Pennsylvania		U.S.A.				PRINCE GEORGES COUNTY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
CLINTON		SOUTHERN MD. HOSPITAL CENTER						homemaker					
13a. STATE MD		13b. COUNTY Prince George's Morningside		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6705 Boxwood Dr. 20746		14. KIND OF BUSINESS OR INDUSTRY home			
14. FATHER'S NAME FIRST George		MIDDLE		LAST Parfitt		15. MOTHER'S MAIDEN NAME FIRST Esther		MIDDLE		LAST Resh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 179-05-9179B		17. INFORMANT (daughter) Shirley Harris		18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u>  DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure</u>		ADDRESS 6705 Boxwood Dr. Morningside, MD 20746				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7 Mar</u> , 19 <u>86</u> , to <u>13 Mar</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12 Mar 86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
23a. SIGNATURE W. OETGEN M.D.		23b. DEGREE				23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-13-86					
23d. PHYSICIAN'S NAME (TYPE OR PRINT) W. OETGEN M.D.		23e. ADDRESS 3611 BRANCH AVE, Temple Hills, MD											
23f. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23g. DATE March 17, 1986		23h. NAME OF CEMETERY OR CREMATORIAL German Protestant Cem.		23i. LOCATION Mahanoy City, Schuylkill, PA							
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc Alexander Ferry Rd., Clinton, MD 20735		25a. DATE REGD. BY REG. DIRECTOR MAR 19 1986		25b. REGISTRAR'S SIGNATURE									
ADDRESS													

1770-00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, and stamped, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma/s, seen, the medical examiner must be notified at once.

00-00358

1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 8 0 8 / 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
ARABELLA E. BANTON						03	11	86	3:00 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		1	24	23	63					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania		U.S.A.					PRINCE GEORGES COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CLINTON		SOUTHERN MARYLAND HOSPITAL CENTER		Secretary			Fed. Gov't.					
13a. STATE Maryland		13b. COUNTY Pr. Gee.		13c. CITY OR TOWN Ft. Wash.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9960 Old Fort Rd. 20744				
14. FATHER'S NAME FIRST Charles		MIDDLE Andrews		LAST		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE		LAST Kiser		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No 578-20-5802		16c. INFORMANT Bernice E. Banton		17. ADDRESS as in item 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18b. DUE TO, OR AS A CONSEQUENCE OF (b) <i>lung &amp; Spleen Chronic Obstructive &amp; Fibrotic Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18c. DUE TO, OR AS A CONSEQUENCE OF (c) <i>lungs</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Community Acq v. red pneumonia</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 11 1986</i> to <i>Mar 11 1986</i> , that (I) (we) lost saw the deceased alive on <i>Mar 11 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>David Robb, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-11-86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Robb, M.D.		22e. ADDRESS 9401 Indian Head Hwy, Ft. Washington MD 20744										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-86		23c. NAME OF CEMETERY OR CREMATORIAL Old Herman Church Cem.		23d. LOCATION CITY OR TOWN Appomattox		COUNTY		STATE Appomattox Va.		
24. FUNERAL DIRECTOR NAME G.P. Kalas F.M.		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR 20745 MAR 14 1986		25b. REGISTRAR'S SIGNATURE <i>John Pendleton</i>						
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*3-17-86 City Hospital Chiropractic Adjustment*

-2-1502

• 5', 11' 10") . 18' 11" zero 0.62' 1.1' net 1.7' 0

00-03056

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8608723

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>AVADAN</b>				2a. DATE OF DEATH 03-28-86	MONTH YEAR 03-86	2b. HOUR 11:05AM M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 2 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CHEVERLY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16e. STREET ADDRESS / ZIP CODE <b>2309 Romey Court 20781</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>Unkn.</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>232-34-6022</b>		17. INFORMANT <b>Mr. Willie Laster - Same as #13</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		(a) <b>Cardiopulmonary arrest</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(c)		DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>3126</b>		CITY OR TOWN <b>3128</b>	COUNTY <b>86</b>
22a. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> , 19 <b>86</b> to <b>3/28</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>Henry H. Yu</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/30/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry H. Yu</b>		22e. ADDRESS <b>3611 Branch Ave. Temple Hills, MD 20748</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>3-31-86</b>		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN <b>Baltimore, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 10 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julie Leiden-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be completed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon copy of item 1 and 2 should be detached with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 6 0 8 / 2 4					
1- STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST									2a. DATE KNOWN OF ESTI- M. 3-31 1986					
			<i>Daniel Barner</i>									<input checked="" type="checkbox"/> MONTH DAY YEAR					
3. SEX Male			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 3-31 1986 6p.m.					
						June 26, 1935		50 yrs.		MONTHS DAYS HOURS MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? USA									8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse			12b. KIND OF BUSINESS OR INDUSTRY 20801		
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN Lanham			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4514 Kinmount Road					
14. FATHER'S NAME Charles						Barner			15. MOTHER'S MAIDEN NAME Irene			Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 577 42 4220			17. INFORMANT Daniel L. Barner, Jr. - son - 1778 Village Green Drive, Landover, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive cardiovascular disease with congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Deceased</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Deceased</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>None</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 3-31-86					
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct, Temple Hills, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 4, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Cheltenham Veterans Cemetery			23d. LOCATION CITY OR TOWN Cheltenham			COUNTY STATE Maryland					
24. FUNERAL DIRECTOR NAME <i>John T. Stewart III</i>			24a. DATE REC'D. BY REGISTRAR APR 02 1986			24b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>											
Stewart Funeral Home - 4001 Benning Road, N.E.																	

00150-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial-troupe form. Then please remove columns 1 and 2 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608725
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST NICHOLAS	MIDDLE	LAST BARRICK	2a. DATE OF DEATH 3/5/86	MONTH 3	DAY 5	YEAR 86	2b. HOUR 1:25AM
3. SEX Male			4. RACE White		5. DATE OF BIRTH Oct. 18, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS YRS	
7a. BIRTHPLACE COUNTRY Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY			MD.
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE GENERAL HOSPITAL		12a. USUAL OCCUPATION Restaurant		12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. PG			13b. COUNTY Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1902 Charleston Place			
14. FATHER'S NAME Peter			15. MOTHER'S MAIDEN NAME Marianna		16. SOCIAL SECURITY NO. 578 46 9606		17. INFORMANT ADDRESS 2313 Drexel St., Hyatts. Md.			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) None			18b. IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY CARDORESPIRATORY FAILURE		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			(b) METASTATIC CARCINOMA							
			(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>2-16</u> , 19 <u>86</u> , to <u>3-5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Mrs. Nayar</u>			22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3-5-86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) SANKARAN M. NAYAR, M.D.			22f. ADDRESS 3717 38th Ave., BRENTWOOD, MD 20720							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/7/86		23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery		23d. LOCATION Washington, D.C.		STATE	
24. FUNERAL DIRECTOR Hines/Rinaldi			11800 New Hamp. Ave. Silver Spring, Md. 20904		25a. DATE REC'D. BY REGISTRAR MAR 6 1986		25b. REGISTRAR'S SIGNATURE <u>John Anderson, Jr.</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08 / 26			
1- STATE REGISTRAR 4/8/86 rja												REG NO.			
1. DECEASED NAME FIRST MIDDLE LAST												2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
(TYPE OR PRINT) PAMELA D. BELLANI												03-9-86 19		MONTH DAY YEAR	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
				Feb 14, 1968 18 RS.				MONTHS DAYS		HOURS MIN		3-9-86 19		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County		MD.					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Morningside		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6812 Woodland Road		20746					
14. FATHER'S NAME FIRST Peter		MIDDLE A		LAST Bellani		15. MOTHER'S MAIDEN NAME FIRST Barbara		MIDDLE A		LAST McKeown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ==		17. INFORMANT Barbara A Phipps		ADDRESS Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Margarita A. Krell, M.D.												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Krell, M.D. ADDRESS 111 Penn Street												DATE SIGNED 3-9-86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 March 86		23c. NAME OF CEMETERY OR CREMATORIAL Washington National		23d. LOCATION CITY OR TOWN Cemetery Suitland		COUNTY PG		STATE MI					
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		ADDRESS Funeral Home		25a. DATE REC'D. BY REGISTRAR MAR 12 1986		25b. REGISTRAR'S SIGNATURE									
DMMH - 17 (VR A15 ME (5))															



00-00355

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 0 0 8 / 2 1

1. DECEASED NAME <b>Joseph Anthony Bello</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <b>March 10 86</b>	2b. HOUR <b>2200</b>										
2. SEX <b>Male</b>			3. RACE <b>White</b>	4. DATE OF BIRTH <b>June 16, 1936</b>	5. AGE (IN YEARS LAST BIRTHDAY) <b>49</b>	6. IF UNDER 1 YR. MONTHS <b>15</b>	7. IF UNDER 24 HRS. HOURS <b>1</b>	8. MARRIED WIDOWED <b>MARRIED</b>	9. NEVER MARRIED DIVORCED <b>NEVER MARRIED</b>	10c. DATE MONTH <b>March 11 1986</b>	10d. DAY <b>11</b>	10e. YEAR <b>1986</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED WIDOWED <b>MARRIED</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b>					
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>9330 Edmonston Road, Apt. #104</b>			11a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>O'Rion Pictures</b>					
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Greenbelt</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>9330 Edmonston Road, Apt. #104</b>		
14. FATHER'S NAME FIRST <b>Angelo</b>			MIDDLE <b>F.</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Carmela</b>			16. LAST <b>Longo</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>578-44-6440</b>			17. INFORMANT <b>Marie Taney (Sister) Seabrook, Maryland</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Inv.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20706</b>		
20. MEDICAL CERTIFICATION <i>None</i>			21. DATE OF OPERATION <i>None</i>			22. CONDITION FOR WHICH OPERATION WAS PERFORMED?			23. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			25. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			26. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			27. DATE SIGNER <i>John S. Rogers, M.D.</i>					
28. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			29. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			30. LOCATION STREET CITY OR TOWN COUNTY STATE			31. TITLE (SPECIFY) <i>John S. Rogers, M.D.</i>					
32. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			33. EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>			34. ADDRESS <b>1919 Seminary Road Silver Spring, Md.</b>			35. DATE SIGNER <i>John S. Rogers, M.D.</i>					
36. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			37. DATE <b>3/15/86</b>			38. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>			39. LOCATION CITY OR TOWN <b>Silver Spring Montgomery Md.</b>					
40. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>			41. DATE REC'D. BY REGISTRAR <b>MAR 14 1986</b>			42. REGISTRAR'S SIGNATURE <i>John S. Rogers, M.D.</i>			43. DATE SIGNER <i>John S. Rogers, M.D.</i>					
44. DHMH - 17 (VR A15 ME (5))			45. DATE SIGNER <i>John S. Rogers, M.D.</i>			46. DATE SIGNER <i>John S. Rogers, M.D.</i>			47. DATE SIGNER <i>John S. Rogers, M.D.</i>					

63800-00



00-01929

1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08/28

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
<i>Robert Edward Bennett Sr.</i>						<input type="checkbox"/> 3-26	1986		1986	12P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
<i>Male</i>	<i>White</i>	<i>3/21/30</i>	<i>56 yrs.</i>	MONTHS	DAYS	<i>3-26</i>	<i>1986</i>	<i>12P</i>	<i>M</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGE'S Co. MD.				
<i>Wash., DC</i>	<i>USA</i>			<i>20613</i>			<i>US Govt.</i>				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
<i>Aquasco</i>	<i>19211 Aquasco Rd</i>					<i>Plumber</i>					
12b. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS	12b. KIND OF BUSINESS OR INDUSTRY		
<i>MD</i>	<i>PR. GEO.</i>	<i>BRANDYWINE</i>						<i>19211 Aquasco Rd</i>	<i>20613</i>		
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST					MIDDLE	LAST		
<i>CLYDE</i>	<i>CARSON</i>	<i>BENNETT</i>	<i>BLANCHE</i>					<i>HATTIE</i>	<i>BENNETT</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>	<i>578-34-6076</i>	<i>ELIZABETH M. BENNETT</i>	<i>Carcinoma of lungs. with hemoptysis</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?					
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET					CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE	<i>Augusto P. Rodriguez</i>					TITLE (SPECIFY) <i>M.D.</i> Deputy MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)	<i>Augusto P. Rodriguez, M.D.</i>					DATE SIGNED <i>3-26-86</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL					23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE		
<i>Burial</i>	<i>3/31/86</i>	<i>Trinity Memorial</i>					<i>Waldorf</i>	<i>Charles</i>	<i>MD</i>		
24. FUNERAL DIRECTOR	ADDRESS					25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
	<i>HUNTT FUNERAL HOME, WALDORF, MD</i>					<i>MAR 31 1986</i>	<i>Guadalupe Rodriguez</i>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 6 0 8 / 2 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
MARJORIE W. BERNARD						FEBRUARY	26	1986		7:57 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Female		White		April 21, 1908		77 yrs.			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
North Carolina		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince Georges County MD.			Andrews USAF			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									12b. KIND OF BUSINESS OR INDUSTRY	
Malcomb Grove											Entertainer	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			20143	
Maryland		Prince Geo Capt. Heights		NO <input type="checkbox"/>		5012 Lee Jay Court						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			
Albert Oglesby						Bertha			unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			578 16 3163			George E. Bernard, spouse-same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Cardio pulmonary failure</i>												
DUE TO, OR AS A CONSEQUENCE OF <b>SECONDARY TO ACIDOSIS</b>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Secondary to acidosis</i>												
DUE TO, OR AS A CONSEQUENCE OF <b>SECONDARY TO RENAL FAILURE SEPSIS HEPATIC FAIL</b>												
(c) <i>Secondary to renal failure 2<sup>o</sup> Sepsis and Hepatic failure</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>13 Jan</u> , 19 <u>86</u> , to <u>26 Feb</u> , 19 <u>86</u> , that (II) (we) last saw the deceased alive on <u>26 Feb</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Timothy Ladner</i>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												
TIMOTHY LADNER												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Cremation			2/28/86		Cedar Hill Crematory		Suitland PG		Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert E Wilhelm Funeral Home						MAR 06 1986			<i>John Davidson Pendleton</i>			
4308 Suitland Road Suitland Maryland												

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the top portion. Return the bottom portion to the State Director of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECORDED BY: \_\_\_\_\_

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

210570



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, RETAIN IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WASHINGTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 0 8 / 3 0		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
MATTIE Lucille Wallace BETTS						<input checked="" type="checkbox"/>	<input type="checkbox"/>	3	28	19	86	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR		
Female	Black	July 25, 1932 53 yrs.		MONTHS	DAYS	HOURS	MIN.	3	28	19	86	10:49 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
South Carolina		United States						Prince George's County MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cheverly		Prince George's General Hosp.						Salesperson/Casual Corner (20706)						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland			13b. COUNTY P. G.			13c. CITY OR TOWN Lanham			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7818 Dellwood Avenue	
14. FATHER'S NAME FIRST Roper		MIDDLE	LAST Wallace	15. MOTHER'S MAIDEN NAME Emmie Jennings										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-50-4033			17. INFORMANT 7818 Dellwood Ave. Lanham, Md.			Leonard Bernard Betts (husband)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Thoraco-abdominal trauma DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10xxx 3-28- 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			Driver of auto/van collision.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			Glenarden Pkwy & Rt. 704, Glenarden, MD Prince George's Co.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												ADDRESS 111 Penn St., Balto., MD 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/03/86		23c. NAME OF CEMETERY OR CREMATORIAL Maryland National			23d. LOCATION CITY OR TOWN Laurel, P.G.C., Maryland		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home ADDRESS 3831 Georgia Ave. NW; Washington, DC 20011		25a. DATE REC'D. BY REGISTRAR APR 11 1986			25b. REGISTRAR'S SIGNATURE 									

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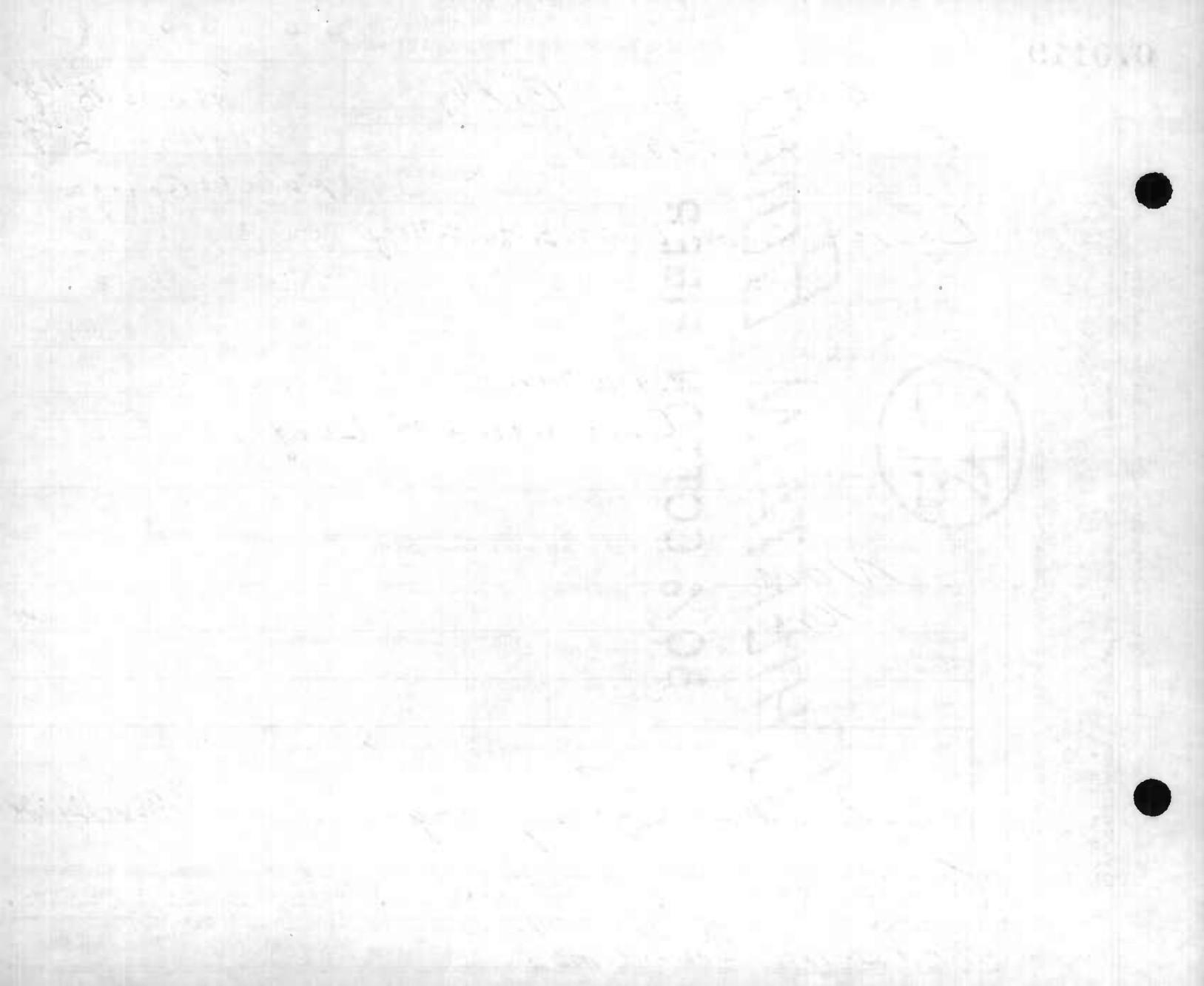
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8608731

1-  
FOR  
STATE  
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)										FIRST <i>Alice J.</i>	MIDDLE <i>Bixby</i>	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH <i>March 1986</i>	DAY <i>8</i>	YEAR <i>1986</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH <i>Feb.</i>	DAY <i>8</i>	YEAR <i>1967</i>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>67</i>	7. IF UNDER 1 YR. MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD	MONTH <i>March 2</i>	DAY <i>8</i>	YEAR <i>1986</i>			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Fitchburg, Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Pri. George</i>							
10. CITY OR TOWN OF DEATH <i>Laurel</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Gardenside Bethesda Hosp</i>			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>								
13a. STATE <i>Md.</i>		13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Laurel</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>9331 Whiskey Bottom Rd.</i>		20708							
14. FATHER'S NAME FIRST <i>Wray</i>			MIDDLE <i>Fallwell</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>			LAST <i>Kerrigan</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>034-16-2302</i>			17. INFORMANT <i>Willis Bixby</i>			ADDRESS <i>same as 13e</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>None</i>																
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>J. L. George</i>										TITLE (SPECIFY) M.D. <i>Dep-</i> MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) <i>J. L. George</i>										DATE SIGNED <i>March 12 1986</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/5/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l Cem.</i>			23d. LOCATION CITY/TOWN <i>Arlington</i>		COUNTY	ARLINGTON	STATE <i>Va.</i>					
24. FUNERAL DIRECTOR NAME <i>FLECH F.H. INC.</i>		ADDRESS <i>7601 SANDY SPR. RD. LAUREL, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 7 1986</i>			25b. REGISTRAR'S SIGNATURE <i>J. L. George</i>									

0720.0



**TO HOSPITAL OR AENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN. The low returns that the death cert-rate  
is returned by the Hospital or attending physician.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

3 6 0 8 7 3 2

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED NAME <i>Ella Irene Black</i>			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR					
3. SEX Female			4 RACE Black			5 DATE OF BIRTH MONTH DAY YEAR Apr. 29, 1909			6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges Co., MD.</i>					
10 CITY OR TOWN OF DEATH <i>Clinton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Maryland Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY PG			13c. CITY OR TOWN Clinton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Nursing Clinton Convalescent Home 20735		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ed Tolbert</i>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula Johnson</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b SOCIAL SECURITY NO. <i>579 16 9493</i>			17 INFORMANT ADDRESS <i>Wendell M. Black-son-4301 23rd Park</i>								
18 CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>way</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) <i>Offshoots of heart Disease</i>														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonia -</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>3/16</u> , 19 <u>86</u> , to <u>3/19</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE <i>M. Mostman</i>			22c. DEGREE <i>Mrs.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>3/20/86</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. Mostman</i>			22f. ADDRESS <i>4235 28th Avenue, Temple Hills, MD 20748</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE <i>March 24, 1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln Memorial Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Suitland, Md.</i>					
24. FUNERAL DIRECTOR NAME <i>John T. Stewart III</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 31 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Brendelle</i>					
Stewart Funeral Home-4001 Beale, RD. N.E.														

70510-0



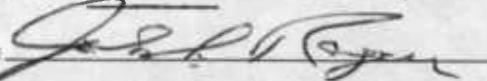
00-02653 3 6 0 8 / 3 3

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.							
1- STATE REGISTRAR																			
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
GORHAM			EUGENE			BLAIR						<input checked="" type="checkbox"/>				M			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN		
Male			Black			02 13 38			48										
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7d. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			2c. DATE PRONOUNCED DEAD							
Maryland			USA									Mar 29 1986				Mar 29 1986 7a.m.			
III. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Brandywine			14217 South Springfield Rd									Prince Georges MD							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
			Maryland			Prince Geo			Brandywine					14217 South Springfield Rd. 20613					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			ADDRESS							
Francis						Blair			Alberta			Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
YES 156 - '59			217-34-0937			Shirley M. Blair SAA													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Cardio-renal failure</b> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Augusto P. Rodriguez, M.D.</i> TITLE (SPECIFY) Deputy MEDICAL EXAMINER																			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
Burial			4/2/86			Md. Veterans Cem.			Cheltenham, P.G. Md.										
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Martell Adams, Aqua co Md									APR 04 1986			<i>John Pendleton</i>							
07/84	BP	DHMH - 17	(VR A15 ME (5))																

33810-0

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.				
1- FOR STATE REGISTRAR			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3/23 1986									2b HOUR MONTH DAY YEAR 2:45				
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST							
Hardy									Blakney							
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS						
Male		Black		Jan. 20, 1921		65 yrs.		MONTHS		DAYS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD 3/24 1986				
Mt. Rainier			4200 Kaywood Drive, #1									9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Mt. Rainier			Prince George's			Mt. Rainier			X			4200 Kaywood Drive, #1				
13a STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Mt. Rainier			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4200 Kaywood Drive, #1				
14. FATHER'S NAME Norman B. Blakney						15. MOTHER'S MAIDEN NAME Idell						McCall				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 263-14-5977			17 INFORMANT Lillie J. Marshall Chicago, Ill.			ADDRESS			9956 Singerman				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>  (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF  (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?							
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE 													TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER 1919 Seminary Road ADDRESS Silver Spring, Montgomery County, Md.	DATE SIGNED 3/24/86		
EXAMINER'S NAME (TYPE OR PRINT)			John S. Rogers, M.D.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-4-86			23c. NAME OF CEMETERY OR CREMATORIAL Hill Side Cemetery			23d. LOCATION CITY OR TOWN Panama City, Fla.	
Burial																
24. FUNERAL DIRECTOR NAME J.B. Jenkins			ADDRESS 7474 Landover Rd.			25a. DATE OF BURIAL/CREMATION APR 03 1986						25b. REGISTRAR'S SIGNATURE 				
BP																
DHMH - 17 (VR A15 ME (5))																

83-10-30



00 - 00643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked  show any injury, or other traumatic event, the medical examiner must be notified of it.

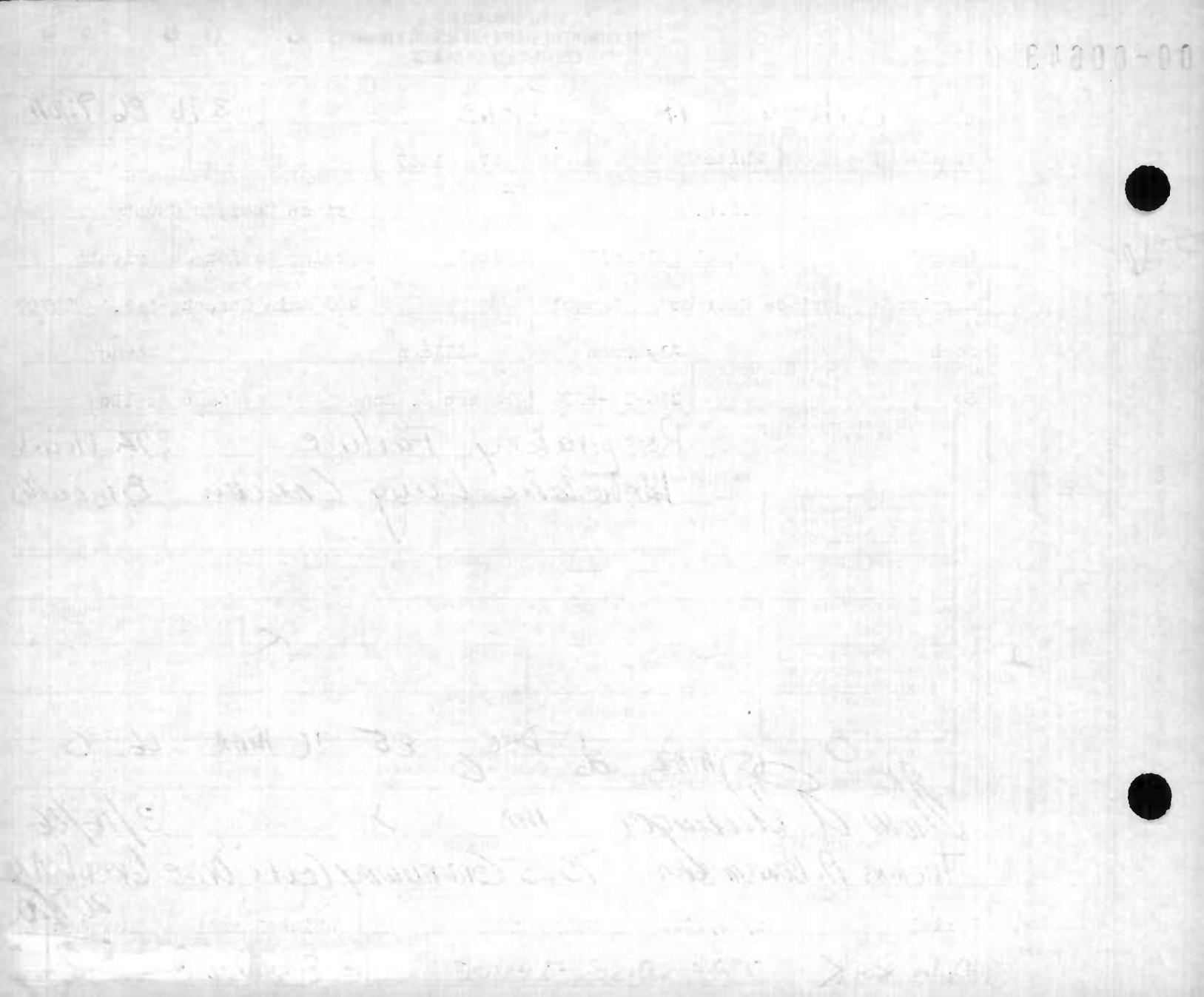
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Eileen R. Bond				3 16 86				9:10A M				
3. SEX	RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR	8. UNDER 24 HRS			
Female	White	MONTH	DAY	YEAR	48	YEARS	MONTHS	DAYS	HOURS	MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince Georges County							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Laurel	Laurel Beltsville Hospital					Nursing Assistant			Private			
USUAL RESIDENCE (IE NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland	Prince Georges	Laurel	Lillian			405 Main Street Apt.A 20707						
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Noah Alverson	Lillian Young											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS							
No	216-34-9538	Robert S. Bond			Same as 13e							
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Melanotic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c)											72 Hours 8 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 15 Dec 85 to 16 Mar 86, to 16 Mar 86, the (I/we) last saw the deceased alive on 15 Dec 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated (I/we) did, and notifying the body after death.											22b. DATE SIGNED	
22c. SIGNATURE Thomas P. Beissinger MD 22d. PHYSICIAN'S NAME (TYPE OR PRINT)											22e. DEGREE	
Thomas P. Beissinger 7525 Greenway Center Drive Greenbelt MD 22e. ADDRESS											22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
Burial		3/19/1986			Holly Hill			White Marsh		20720 Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS											25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Dora Ruck 7922 Louise Avenue											MAR 18 1986	18 Mar 1986

64800-00



072020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	6	0	6
												REG. NO. 08736			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
			French Raymond			BOONE			02 28 86			2:35 AM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male			White			Dec 13, 1900			85 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Virginia			USA						PRINCE GEORGES MD.						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Clinton			Southern Md Hospital			Mechanic			U.S. Gov Navy Yard						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			Pr Geo			Oxon Hill						1820 Knoll Drive 20745			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Robert L Boone			Clevie Kimmer												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No --			233-07-6501			Miriam M Boone			Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Esophageal carcinoma of lung</i>												<i>Months</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive lung disease; Pneumonia</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) <input type="checkbox"/> attended the deceased from <u>3/26</u> , 19 <u>86</u> , to <u>3/28</u> , 19 <u>86</u> , that (1) <input type="checkbox"/> last saw the deceased alive on <u>3/27</u> , 19 <u>86</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> did not view the body after death.															
22b. SIGNATURE <i>L. Kaufman</i>												DEGREE			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L. Kaufman M.D.</i>												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. ADDRESS <i>8926 Woodlawn Rd. Clinton, Md.</i>												22e. DATE SIGNED <i>2/28/86</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 3 March 86			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland COUNTY PG STATE Md						
24 FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home			ADDRESS Suitland, Md.			25a. DATE REC'D. BY REGISTRAR MAR 06 1986			25b. REGISTRAR'S SIGNATURE <i>Jeanne Gordon Pendleton</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The information on this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit slip. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene giving full details of burial, cremation, or removal.

IMPORTANT: If Item 21 is marked  show any injury, or other traumatic event, a medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 3 /

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<b>George</b>					<b>Boubeulis</b>	<b>3</b>	<b>13</b>	<b>86</b>	<b>5:55 PM</b>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
<b>Male</b>		<b>Cauc.</b>		MONTH <b>5</b>	DAY <b>28</b>	YEAR <b>28</b>	<b>57</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
<b>Penna.</b>		<b>USA</b>				<b>Prince George</b>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR PRINT, OR LIST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
<b>Clinton</b>		<b>Southern Maryland Hospital Center</b>		<b>Retired</b>		<b>Researcher</b>						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
<b>Maryland</b>		<b>Pr. George</b>		<b>Camp Springs</b>				<b>5305 Manchester Dr. 20746</b>				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. LAST					
		<b>Anastasines</b>		<b>Boubeulis</b>	<b>Viela</b>		<b>Spierson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>yes</b>		<b>Korea</b>		<b>195-20-3935</b>		<b>Anna F. Antipas Boubeulis same as item 13</b>			<b>3-4 mos.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>												
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF THE LUNG - NON CARCINOID</b>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/85</b> to <b>3/12/86</b> , that (I) (we) last saw the deceased alive on <b>3/13/86</b> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE <i>Ch. Celae</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED <b>3/14/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles F. Celae, M.D.</b>		22e. ADDRESS <b>2704 Riviera St. Marlow Heights, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/17/86</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Washington Nat. Cemetery Suitland P.G. Md.</b>		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>MAR 17 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John D. ...</i>						

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2301 September 1976 X P. George Gross filers

Stereotypes X filers

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.03 same .04 mixed

.05 .06 breathing system .07 notepad

.08 file listing

.09 , HHS next .10 HHS next Date serial .10

00-00890

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSPIRMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08/38

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)						FIRST <i>James</i>	MIDDLE <i>Richard</i>	LAST <i>Bowie</i>	2a. DATE KNOWN OF ESTI- MATED	MONTH <input checked="" type="checkbox"/>	DAY <input type="checkbox"/>	YEAR <i>86</i>	2b. HOUR <i>4:35 PM</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>3</i>	DAY <i>5</i>	YEAR <i>69</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>17 yrs</i>	IF UNDER 1 YR. MONTHS <input type="checkbox"/>	IF UNDER 24 HRS. DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	MIN <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD	MONTH <i>3-17</i>	DAY <i>1986</i>	YEAR <i>86</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>La Plata, Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES</i>						
10. CITY OR TOWN OF DEATH <i>CHEVERLY</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George General Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LABORER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCT.</i>			
13a. STATE <i>MD.</i>		13b. COUNTY <i>CHARLES</i>		13c. CITY OR TOWN <i>PISGAH</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS FIRST <i>MARTHA</i>		MIDDLE <input type="checkbox"/>	LAST <i>Jones</i>				
14. FATHER'S NAME FIRST <i>WILLIAM</i>			MIDDLE <i>WALTER</i>	LAST <i>BOWIE</i>	15. MOTHER'S MAIDEN NAME FIRST <i>MARTHA</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>NONE</i>			17. INFORMANT <i>MARTHA BOWIE</i>	ADDRESS <i>SAME AS #13</i>
18. CAUSE OF DEATH (Enter only one cause in line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>8150</i> IMMEDIATE CAUSE <i>Multiple injuries with severe head trauma</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <input type="checkbox"/>		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION <i>3-10-86</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Head injury</i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10:00 A.M. 3-10 1986</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Driver/ car fixed object impact</i>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>			21f. LOCATION STREET <i>Bellingsgate Ln., White Plains</i>			CITY OR TOWN <i>Charles County, Md.</i>	COUNTY <input type="checkbox"/>	STATE <input type="checkbox"/>				
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		M.D.		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>3-12-86</i>							
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i>		ADDRESS <i>509 Logburn Ct. Camp Springs, Md.</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-14-86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Nanjemoy Church Cem.</i>		23d. LOCATION CITY OR TOWN <i>Nanjemoy</i>		COUNTY <i>Charles</i>	STATE <input type="checkbox"/>		
24. FUNERAL DIRECTOR NAME <i>Arehart Funeral Home, Inc.</i>		ADDRESS <i>La Plata, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 18 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Arehart</i>									
DHMH - 17 (VR A15 ME (5))															

13300-00

GOING ON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM PAGE 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5 FOR YOUR FILES. HE WILL BUILD A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08139

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
<i>Jimmie Ray Bradley</i>							<input checked="" type="checkbox"/> 3-16 86				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1YR.	8. IF UNDER 24 HRS	9. MARRIED	10. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
<i>Male</i>	<i>White</i>	<i>10 1 1926</i>	<i>59</i> YRS.	MONTHS	DAYS	HOURS	<input type="checkbox"/> 3-19 86				<i>4:30 PM</i>
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
<i>Texas</i>		<i>U.S.A.</i>				<input type="checkbox"/> NEVER MARRIED		<i>Baltimore Georges</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Temple Hills</i>		<i>2905 Brinkley Rd. #T-1</i>				<i>U.S.Navy - Ret.</i>		<i>Military</i>			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN				13c. STREET ADDRESS		20748			
<i>Maryland</i>		<i>Prince Georges Temple Hills</i>				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>2905 Brinkley Rd. #T-1</i>					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS				
<i>George</i>		<i>W.</i>	<i>Bradley</i>		<i>Synie</i>		<i>2906 Kenesaw Ave. Wichita Falls, Texas</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		LAST			
<i>Yes</i>		<i>WWII - Korea</i>				<i>George E. Bradley</i>		<i>Stewart</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE				DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		<i>Hypertensive vascular disease</i>									
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		{				(b)					
		{				DUE TO, OR AS A CONSEQUENCE OF					
		{				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I-(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		<i>Augusto P. Rodriguez</i>				TITLE (SPECIFY)		DATE SIGNED <i>19 Mar 86</i>			
EXAMINER'S NAME (TYPE OR PRINT)		<i>Augusto P. Rodriguez, M.D.</i>				ADDRESS		5009 Rayburn Ct., Temple Hills, MD			
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
<i>Burial</i>		<i>3/24/86</i>		<i>Arlington National Cem.</i>		<i>Arlington</i>		<i>Virginia</i>			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
<i>George P. Kalas Funeral Home Oxon Hill, Md.</i>		<i>6160 Oxon Hill Rd.</i>				<i>MAR 26 1986</i>				<i>John Anderson</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please send carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608140			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Edward	MIDDLE R.	LAST Brady, Sr.	2a. DATE OF DEATH March 5, 1986			MONTH YEAR	2b. HOUR 5AM			
3. SEX Male			4. RACE White		5. DATE OF BIRTH NOV. 2 <sup>y</sup> 1928		6. AGE (IN YEARS LAST BIRTHDAY) 57		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE North Carolina			7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George			MD.			
10. CITY OR TOWN OF DEATH Adelphi			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 9610 Riggs Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov't.-Dept. of Army			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY PG		14. FATHER'S NAME FIRST George		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9610 Riggs Road 20902			
14. FATHER'S NAME FIRST George			MIDDLE A.	LAST Brady	15. MOTHER'S MAIDEN NAME FIRST Ona			16. SOCIAL SECURITY NO. 242 38 8763			LAST Worrell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. USAF		17. INFORMANT Rose Brady (Wife) Same as 13e			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			cardio-respiratory failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			due to, or as a consequence of (b) carcinoma of lung, spinal metastasis.								6 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).			(c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) <input type="checkbox"/> (we hospital) attended the deceased from November 1, 1985, to March 5, 1986, that (I) <input type="checkbox"/> (we) lost saw the deceased alive on March 5, 1986, and that in (I) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) did (not) <input type="checkbox"/> (not) view the body after death.													
22b. SIGNATURE Surendra R. Rishi			22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED March 5, 1986					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Surendra R. Rishi			22e. ADDRESS 6525, Belcrest Rd, Hyattsville, Md. 20782										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/8/86		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION CITY OR TOWN Brentwood			CO. PG STATE Md.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi			11800 New Hampshire Ave Silver Spring, Md.					25a. DATE REC'D. BY REGISTRAR MAR 6 1986			25b. REGISTRAR'S SIGNATURE John R. Rinaldi		

CONGENITAL MALFORMATIONS OF A	
CONGENITAL MALFORMATIONS OF A	None
CONCURRENT ILLNESSES OR CONDITIONS AFFECTING	22
ELEMENTARY OR SECONDARY (O)	BLACK 11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8608/41

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			WILLIE	L	BRANCH	MARCH	26	1986	10:05AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		Negro		Month Day Year April 11 1942		43		YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Prince George's MD.			
U.S.A. N.C.		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Lanham, Md.		Doctors' Hospital of Pr. Geo. Co.		Chauffuer		Private					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE					
Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2904 BrightSeat Road Apt.		20785 Apt. 203	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	ADDRESS	
Earl				Tatum	Adna		Lee		Branch	Deborah A. Carroll, Friend, Greenwood, S.C. 29646	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		218-66-7679		1308 East CambridgeAnvne,		3 months					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						Liver Failure					
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Gastric Carcinoma						18 months					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 26 Mar 1986 to 26 Mar 1986, that (I) (we) last saw the deceased on 26 Mar 1986, and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.											
22b. SIGNATURE DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>											
22c. DATE SIGNED 3/26/86											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 205 7525 Greenway Center, Greenbelt, Md. 20770									
Thomas A. Bensinger, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE April 21 1986		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION Landover, Md.		STATE			
Burial											
24. FUNERAL DIRECTOR NAME Edward W. Jones		ADDRESS Bacon Funeral Home, 3447-14th St. N.W.		25a. DATE REC'D. BY REGISTRAR APR 1 - 1986		25b. REGISTRAR'S SIGNATURE					
						G. Bensinger-Pendell					
BP											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

31050-00



4-80-A

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 3 AND 25 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08 / 42	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR		
<i>Helen C. Brennan</i>						<i>March 21 1986</i>			<i>Mar</i>	<i>21</i>	<i>1986</i>		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
<i>F</i>		<i>W</i>		<i>July 29 88</i>		<i>87</i>							
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		7d. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		7e. DATE PRONOUNCED DEAD <i>March 21 1986</i>							
Pennsylvania		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
<i>Laurel</i>		<i>Greater Laurel Better Health Housewife</i>				<i>Princess George</i>				<i>home</i>			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>12707 Cedars Brook Lane</i>					
<i>Md</i>		<i>Prince George</i>		<i>Laurel</i>									
14a. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
<i>Patrick</i>				<i>Comerford</i>		<i>Ellen</i>				<i>Brown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no				<i>173 32 3935</i>		<i>Thomas Brennan same as above</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Acute Myocardial Dist.</i>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
{ (b) _____ DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
<i>None</i>												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Rogers</i>		TITLE (SPECIFY) M.D. <i>John Rogers</i>										MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										DATE SIGNED <i>March 22 1986</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
<i>Burial</i>		<i>March 24, 1986</i>		<i>St. Vincent's Cem</i>		<i>Plymouth, Pa</i>							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Donaldson Funeral Home, Laurel, Md				<i>MAR 26 1986 Julie Dearden-Peyrell</i>									
BP _____													
DHMH - 17 (VR A15 ME (5))													

17210-00



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 4 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
William Wadsworth Briesmaster, Sr.						03	02	86	11:25	AM			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
male		Caucasian		MONTH	DAY	YEAR	88			IF UNDER 24 HRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8.			9 BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		U.S.A.		MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Prince George's County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Ft. Washington		Ft. Wash. Rehab. Ctr.			Business Owner			Auto Supplies					
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e STREET ADDRESS / ZIP CODE							
13a STATE MD.	13b COUNTY P.G.	13c CITY OR TOWN TEMPLE HILLS	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2410 GAITHER STREET RJ. 20745							
14 FATHER'S NAME Charles			MIDDLE	LAST	15 MOTHER'S MAIDEN NAME MARY			MIDDLE	LAST	Wilkie			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. 223-09-3122			17 INFORMANT William W. Briesmaster Jr.			ADDRESS 14200 Livingston Rd. Clinton, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Coronary Heart Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
b) Coronary and generalized arteriosclerosis													
DUE TO, OR AS A CONSEQUENCE OF b) Coronary and generalized arteriosclerosis													
DUE TO, OR AS A CONSEQUENCE OF b) Coronary and generalized arteriosclerosis													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I						Transurethral Resection of Prostate and removal of bladder Calculus 2-11-86							
19a DATE OF OPERATION Sept. 5, 1986		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary retention and gross hematuria				19c AUTOPSY		20a IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT OR HAZARDOUS OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED NATURE OF INJURY (IN ITEM 1b, PART I OR PART II)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from Feb. 21, 1986, to 3-2, 1986, that (I) (we) last saw the deceased alive on Feb. 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE Paul B. Bender, M.D.						DEGREE		22c DATE SIGNED 3-2-86					
22d PHYSICIAN'S NAME (TYPE OR PRINT) PAUL B. BENDER, M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b DATE 3/5/86		23c NAME OF CEMETERY OR CREMATORIAL Mt. Comfort Cemetery		23d LOCATION CITY OR TOWN Alexandria		COUNTY	STATE Va.
24 FUNERAL DIRECTOR G.P. Kalas						25a. DATE REC'D. BY REGISTRAR MAR 11 1986		25b. REGISTRAR'S SIGNATURE Vanderbilt					

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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00-01570

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 6 0 8 1 4 4  
REG. NO.

1 - STATE REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR					
BLANDINE			BROOKS			3/17/86			4:45p.m.						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
FEMALE		BLACK		FEB. 11 1888		98 YRS									
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY		10a. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE	
13a. STATE MARYLAND		13b. COUNTY P.G.		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9248 PISCATAWAY ROAD, CLINTON, MD.		20135					
14. FATHER'S NAME WILLIAM BROOKS						15. MOTHER'S MAIDEN NAME ELIZABETH						CARTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-44-3284A		17. INFORMANT ELLEN DOTSON-NIECE-9248 piscataway rd.		ADDRESS				Clinton, Md.			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))  <b>PART I DEATH WAS CAUSED BY:</b>  <b>887</b>  <b>IMMEDIATE CAUSE (a)</b> <u>cardio pulmonary arrest</u>  <b>DUE TO, OR AS A CONSEQUENCE OF</b>  <b>(b)</b> <u>Acute upper G.I. bleeding</u>  <b>DUE TO, OR AS A CONSEQUENCE OF</b>  <b>(c)</b> <u>Acute on chronic renal failure</u></p>															
<p><b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I</b>  <u>CHF/ASCD, Anemia, Fracture(?) hip, urepsys</u></p>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>3-10 19 86</u>, to <u>3-17 19 86</u>, that (I) (we) lost saw the deceased alive on <u>3-17 19 86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>															
22b. SIGNATURE				DEGREE								22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
<u>M. CHANDRA, MD</u>		<u>9131, Piscataway Rd. Clinton, MD</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
BURIAL		3/20/86		ST. JOHNS		Clinton		Maryland		20135					
<p>24. FUNERAL DIRECTOR <u>ALEXANDER S. POPE 2617 PENNSYLVANIA AVE. SUITE 314, 8/86</u></p>															
<p>25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE</p>															

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: When Part 2 is marked or if Part 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon paper. Pages 1 and 2 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

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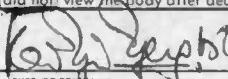
IN

BY

00-02148  
• STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 8 / 4 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>David</b>	MIDDLE <b>Edward</b>	LAST <b>Brown Jr.</b>	2a DATE OF DEATH MONTH <b>Oct. 4, 1912</b>	DAY YEAR <b>1912</b>	2b. HOUR P. <b>9:30 A.M.</b>
3. SEX <b>Male</b>			4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Oct. 4,</b>	DAY <b>1912</b>	6. AGE [IN YEARS LAST BIRTHDAY] IF UNDER 1 YEAR MONTHS <b>73 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b>	
10. CITY OR TOWN OF DEATH <b>Upper Marlboro</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>16302 Mt. Calvert Road</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo's</b>	13c. CITY OR TOWN <b>Upper Marlboro</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>16302 Mt. Calvert Rd./20772</b>	
14. FATHER'S NAME FIRST <b>David</b>			MIDDLE <b>Edward</b>	LAST <b>Brown, Sr.</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Nellie</b>		MIDDLE <b>---</b>	LAST <b>Marr</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-30-2766</b>		17. INFORMANT ADDRESS <b>Eleanor Elizabeth Brown - Upper Marlboro, Md. 20772</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 3-7 1986</b> , to <b>March 19 86</b> , that (I) (we) last saw the deceased alive on <b>Nov 3-7 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE 		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/17/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>8926 Woodyard Road, Clinton, Md. 20735 Suite #201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/19/86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Thomas Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Croom (Pr. Geo's)</b>		
24. FUNERAL DIRECTOR <b>Richard A. Coleman -Upper Marlboro, Md. 20772 Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 02 1986</b>		25b. REGISTRAR'S SIGNATURE 				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 08 / 46

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Failure to do so may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>LOLA</i>	MIDDLE <i>GEM</i>	LAST <i>BROWN</i>	2a DATE OF DEATH MONTH <i>03</i>	MONTH <i>13</i>	DAY <i>86</i>	YEAR <i>6:09 PM</i>	2b HOUR <i>6:09 PM</i>
3. SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH <i>9/3/1886</i>			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>99</i>			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE COUNTRY <i>Missouri</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES MD.</i>				
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Md Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Own home</i>				
13a STATE <i>MD</i>		13b COUNTY <i>Pr. Geo.</i>		13c CITY OR TOWN <i>Accokeek</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>15703 Livingston Rd/20607</i>			
14. FATHER'S NAME FIRST <i>Mark</i>		MIDDLE <i>McPheeters</i>		LAST		15. MOTHER'S MAIDEN NAME FIRST <i>Piney</i>		MIDDLE		LAST <i>Heart</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>577-16-9491</i>		17 INFORMANT <i>Daughter Evelyn Streater</i>		ADDRESS <i>same as 13</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.) <i>315</i>		21f LOCATION STREET <i>315</i>		CITY OR TOWN <i>19 86</i>		COUNTY <i>313</i>		STATE <i>19 86</i>	
22a I certify that (I) (this hospital) attended the deceased from <i>3 10</i> to <i>19 86</i> , to <i>3 13</i> to <i>19 86</i> , that (II) (we) lost saw the deceased alive on <i>3 15</i> to <i>19 86</i> , and that in (my) ( <input type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>William Kent Hunt MD</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>3/14/86</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. FURST m.D.</i>		22e ADDRESS <i>11701 Livingston Rd. Ft. Wash. md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/17/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Trinity Memorial</i>		23d. LOCATION CITY OR TOWN <i>Waldorf</i>		CITY OR TOWN <i>Charles</i>		COUNTY STATE <i>MD</i>	
24. FUNERAL DIRECTOR NAME <i>HUNTT FUNERAL HOME, INC., WALDORF, MD</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>MAR 17 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Hunt</i>					

3110-00

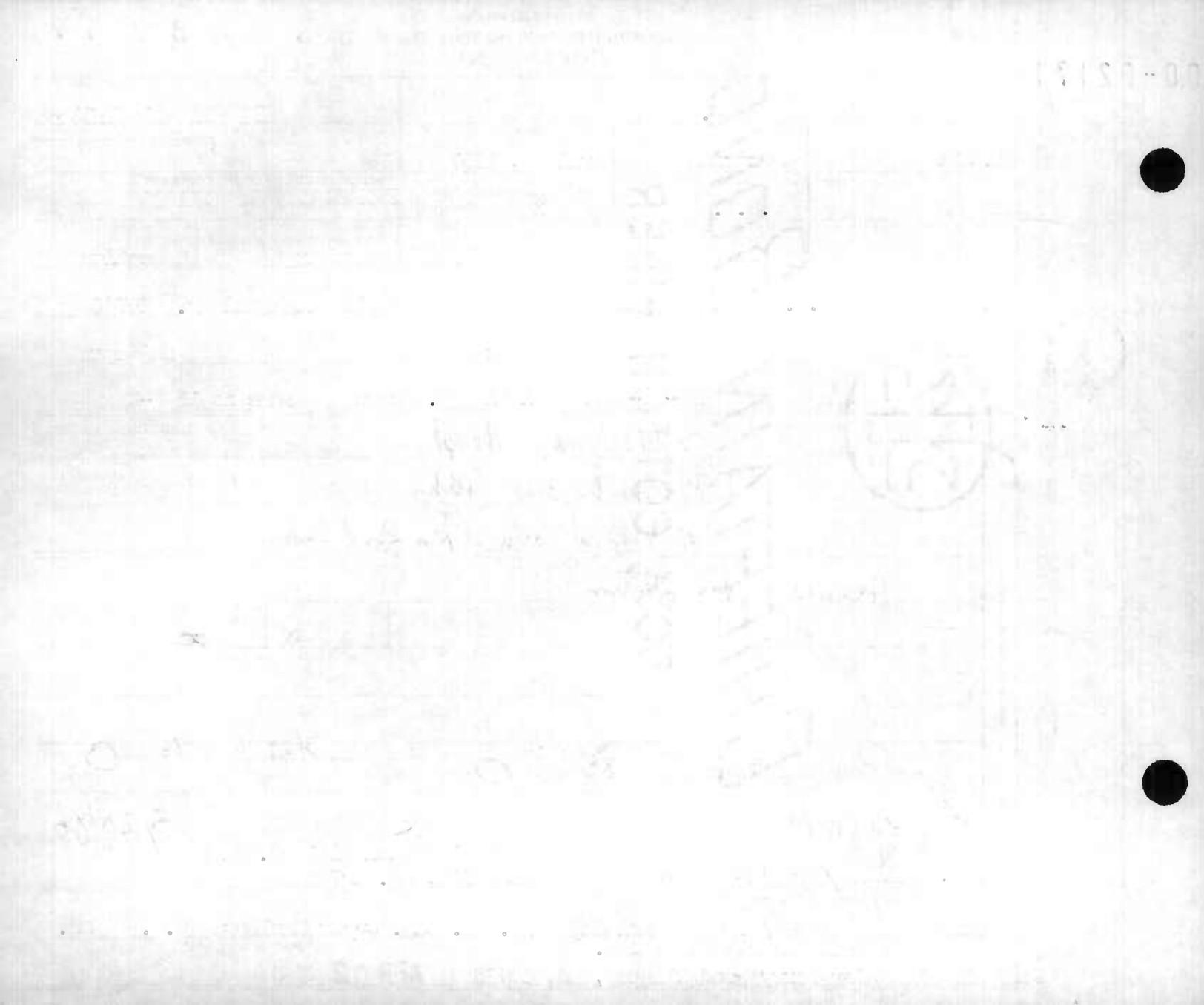
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 08 / 41					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
MARY			B.		BROWN	03			29	86		2:04 p.m.			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR				
Female			Caucasian		April 8, 1907			78			MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			8. IF UNDER 24 HRS				
Maryland			U.S.A.					PRINCE GEORGES COUNTY			MONTHS DAYS				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
CLINTON			SOUTHERN MARYLAND HOSPITAL CENTER										Teacher		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			P.G.		Camp Springs			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6535 Beechwood Dr. 20748				
14. FATHER'S NAME FIRST			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
James					Bennett	Sarah						Snideman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			N/A		213-38-1707			William M. Brown			Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Endotracheal intubation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute Renal Failure from Renal Failure</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Anemia</i> <i>Hypertension</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
19c.										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (we) attended the deceased from <i>3/29/86</i> , 19 <i>86</i> , to <i>5/22/86</i> , 19 <i>86</i> , that (1) (we) last saw the deceased alive on <i>3/29/86</i> , 19 <i>86</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>G. Grover</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3/30/86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Grover / Edgecombe</i>			22e. ADDRESS 6188 Oxon Hill Rd. #200 Oxon Hill, Md. 20745												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 104/02/86			23c. NAME OF CEMETERY OR CREMATORIUM Trinity Epis. Ch. Cem.			23d. LOCATION Upper Marlboro P.G. Md.						
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6633 Old Alexander Ferry Road Clinton, Md. 20735						25a. DATE REC'D. BY REGISTRAR APR 02 1986			25b. REGISTRAR'S SIGNATURE <i>Handwritten Signature</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

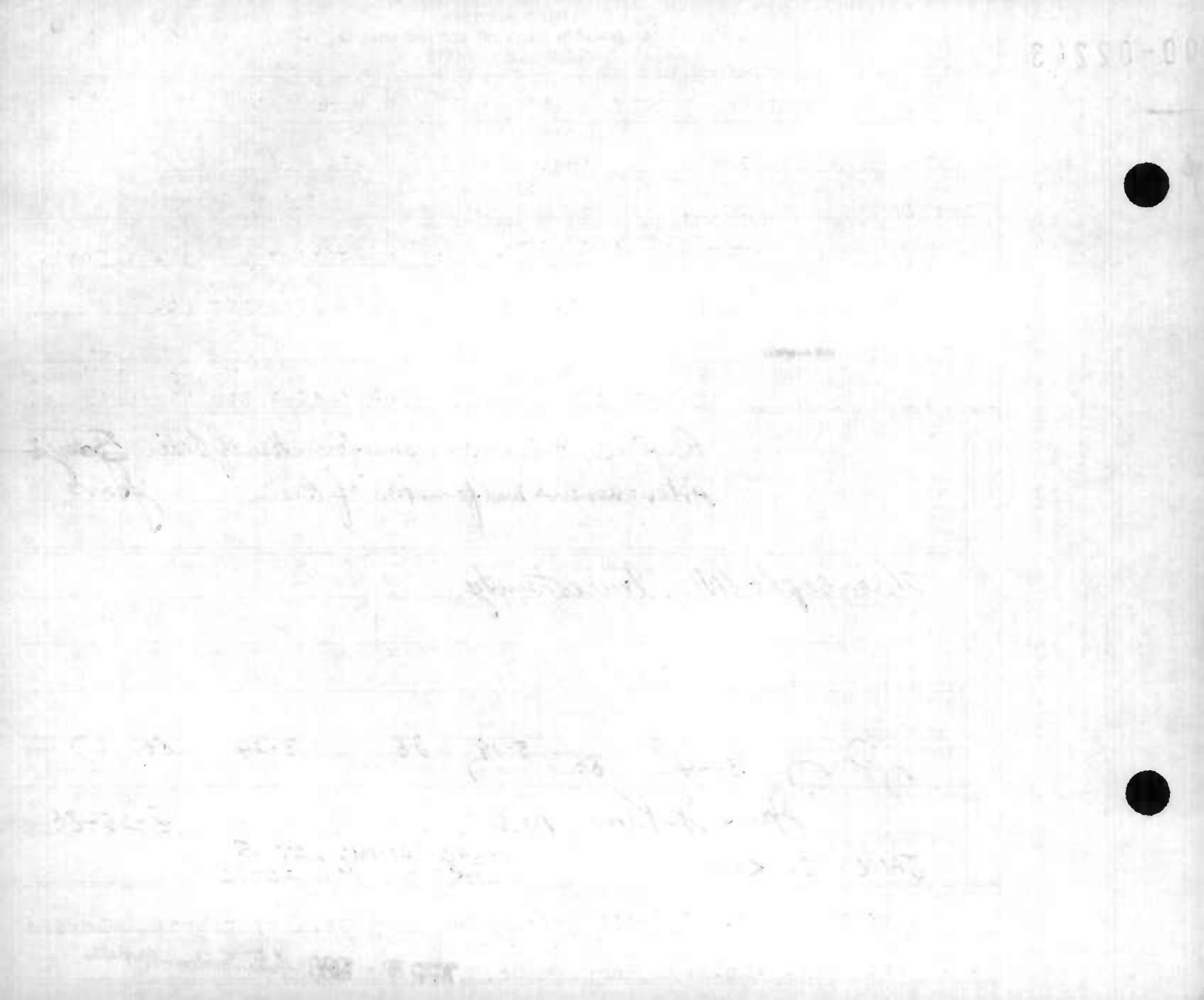
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove with the copy of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 8 / 4 8							
										REG. NO.							
1 - FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		WILLIAM HENRY BROWN III									March 24		1986			12:13P M	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		Black			Month Day Year			41			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Florida		U.S.A.			Aug. 16, '44			Prince George's									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Lanham		Doctors' Hospital of Pr. Geo. Co.			Printer			U.S. Govt.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		20870						
Maryland		J.H.		Upper Marl.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			310 Alastair St.								
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			FIRST		MIDDLE		LAST		Geiger						
Theodore		Brown			Mildred						Upper Marlboro, Md						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/>		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No		267-74-2415			Jannie Brown (Wife)			310 Alastair St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN CAUSES OF DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) Anterior venous malformation of brain							
										DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (we) attended the deceased from saw the deceased alive on above (I) (we) (did) did not view the body after death.		3-24 19 86			3-19 19 86 to 3-24 19 86			that (I) (we) lost									
22b. SIGNATURE		JAMES J. KIM M.D.			DEGREE			22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)							
								3-25-86		JAMES J. KIM			ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Burial		Mar. 31, 86			All Faiths Cemetery St. Petersburg, Florida			Wash. D.C.									
24. FUNERAL DIRECTOR NAME		ADDRESS															
R.N. Horton Co. Inc. 600 Kennedy St. N.W. APR 1 1986																	

00-055(2)



00-01411

08/49

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Espey			T.		Browning, Sr.	3	21	86	11:50 pm		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					
Male		White		September 1, 1909		76					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		U.S.A.				Prince George's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale		5700 Nicholson Street				Collection Officer Internal		Revenue			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Pr. Geor.	Riverdale			5700 Nicholson Street 20737					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Perry	W.	Browning			Anna	Virginia	Espey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
Yes - Army		W.W.II		215-44-8776		Marguerite S. Browning (Wife) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Advanced Metabolic Cerebral Disease 7 yr</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-21-1986</i> to <i>3-21-1986</i> that (I/we) last saw the deceased alive on <i>3-15-1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>M. Baig</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/21/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Laurel, Maryland							
Mahmoodullah Baig		3450 Ft. Meade Rd. #109 20707									
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 3/25/86		23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN Silver Spring Montgomery Md.					
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons, P.A.		4739 Baltimore Ave. Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR MAR 26 1986		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked

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APR 11 1968 FBI - BOSTON

11410-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

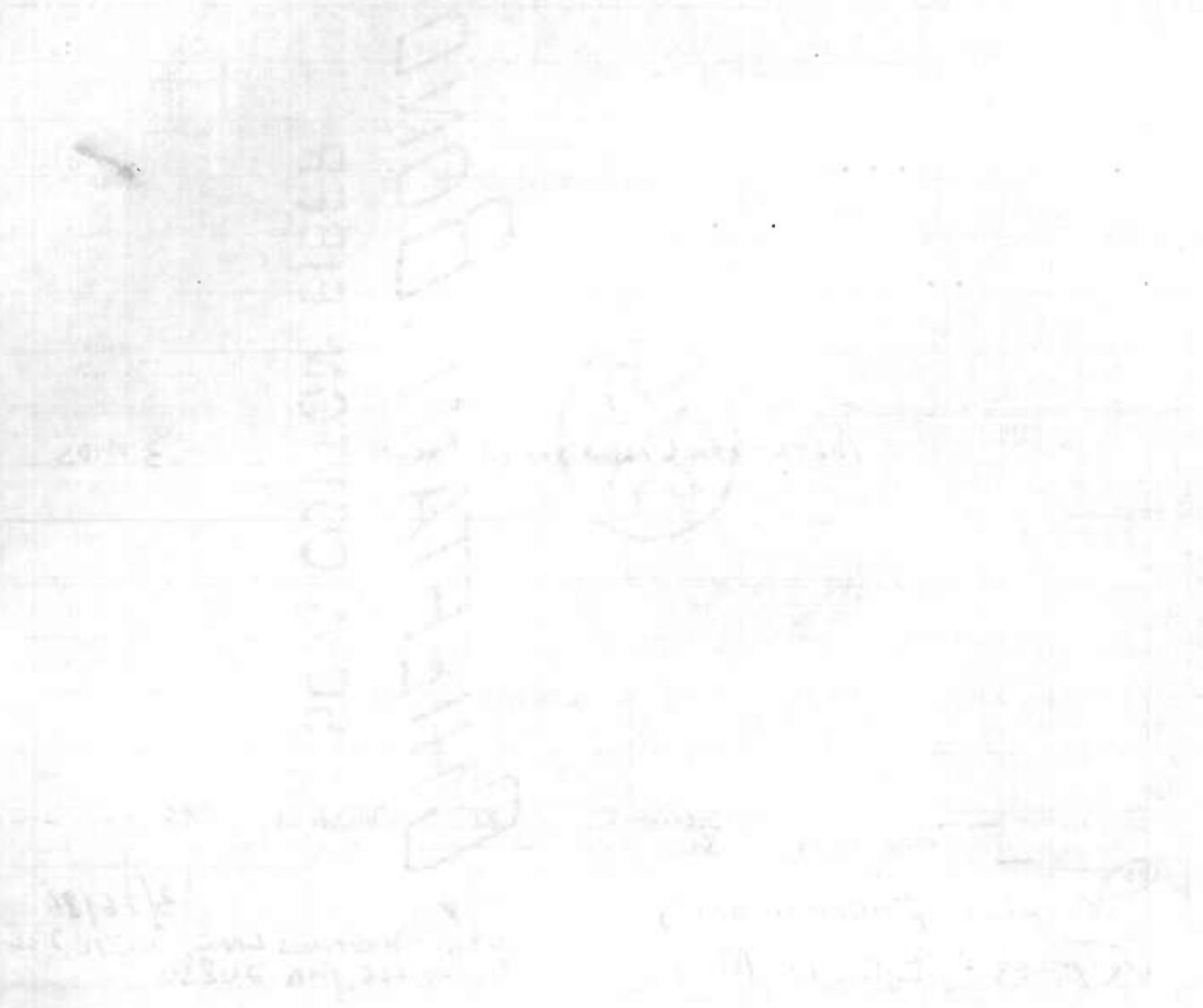
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the funeral director for 24 hours after death with the State Dept. of Health and Mental Hygiene until 10:00 a.m. on the day of burial, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 / 5 0					
										REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			RAYMOND O. BURCH						03		26	86		18:50 M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			IF UNDER 24 HRS			
MALE		WHITE		MONTH 06 DAY 24 YEAR 15			70		MONTHS DAYS			HOURS MIN.			
YRS.		8. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MD.		U.S.A.							Prince George County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
RIVERDALE		LELAND MEM. HOS.			Dispatcher			Cash Reg. Co.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE					
13b. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN HYATTSVILLE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3107 KELLIHER RD. 20782						
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
Ernest			Burch			Agnes			May			Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			3105 Kelliher Rd.					
Yes		World War II		577053465			James R. Burch - Hyattsville, Md. 20782								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Metastatic carcinoma of Colon										3 mos					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (the hospital) attended the deceased from DECEMBER 19, 85, to MARCH 26, 1986, that (I) (we) last saw the deceased alive on MARCH 25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										22c. DATE SIGNED					
22b. SIGNATURE James A. Brown and James A. Brown, MD										DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			14800 PHYSICIANS LANE SUITE 232 ROCKVILLE MD 20850										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		3/29/86		Park Heights Cem.			Brunswick, Frederick, Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
John T. Williams Funeral Home Brunswick, Md.					APR 3 1986		Julie L. Johnson								

00-09254



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death; death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	0	8	/	5												
										REG. NO.																	
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR P									
			Leah			NMI				BURGER		March 12, 1986						11:41 M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS (AS AT BIRTHDAY))			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS												
Female			Caucasian			MONTH DAY YEAR June 16, 1920			65 YRS			MONTHS DAYS			HOURS MIN.												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Prince George's County															
Washington, D. C.			U.S.A.																								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																		
Lanham			Doctors' Hospital of Prince Geo Co			Bookbinder			Bookbinding																		
13a. STATE Maryland										13b. COUNTY Prince George's Landover		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6903 Sheperd Street 20784										
14. FATHER'S NAME Phillip										15. MOTHER'S MAIDEN NAME Goldblatt			FIRST			MIDDLE			LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORATES) No N/A			17. INFORMANT Jacqueline Carter			ADDRESS Same as 13 A-E																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1h																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF malignant lymphoma.										1h.																	
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE														
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 83</u> , 19 <u>86</u> , to <u>March 12, 1986</u> , that (I) (we) last saw the deceased alive on <u>Mar 12</u> , 19 <u>86</u> , and that in [my] (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																											
22b. SIGNATURE <i>Maxine J. Miller</i>			22c. DEGREE DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/13/86																		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARIN D. MILLER 7525 Greenway Ln NW Greenbelt MD 20770</i>			22e. ADDRESS																								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 03-17-86			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.			23d. LOCATION CITY OR TOWN Arlington			COUNTY Arlington		STATE Va.													
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS Old Alexander Ferry Road, Clinton, Md 20735									25a. DATE REC'D. BY REGISTRAR MAR 19 1986			25b. REGISTRAR'S SIGNATURE															
6633																											

10100-00

15 SEP 1968  
15 SEP 1968



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201, BALTIMORE, MARYLAND.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08752				
1 - STATE REGISTRAR			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 29 1986									7b. HOUR M				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2c DATE PRONOUNCED DEAD MONTH DAY YEAR 3 29 1986			2d HOUR Noon	
BRANDON									CABNESS			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		10. CITY OR TOWN OF DEATH Cheverly		
Male		Black		Sept. 15, 1985			YRS.			6				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		USA						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY	
Maryland															20743	
13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Captiol Hgts.												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4913 Emo Street		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO. None			17. INFORMANT Ms. Donna Roy-mother-4913 Emo St., Capt.	
Eugene						Cabness			Donna						Roy	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			18b. SOCIAL SECURITY NO. None			18c. ADDRESS Hgts., Md			18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
no																
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial April 4, 1986 Lincoln Memorial Cemetery Suitland, Maryland												DATE SIGNED 3-30-86				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., MD 21201													
Ann M. Dixon, M.D.																
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial April 4, 1986 Lincoln Memorial Cemetery Suitland, Maryland			25b. NAME OF CEMETERY OR CREMATORIUM									25c. LOCATION CITY OR TOWN		25d. COUNTY STATE		
25e. FUNERAL DIRECTOR NAME John T. Stewart, Jr.			25f. DATE REC'D. BY REGISTRAR APRO 2 1986									25g. REGISTRAR'S SIGNATURE				
Stewart Funeral Home 4001 Benning Road, N.E.																
DHMH - 17 (VR A15 ME (5))																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked with a checkmark, the medical examiner should be notified.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 0 8 / 5 5							
				REG. NO.							
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		1a FIRST <b>PHILIP B</b>		1b MIDDLE <b>CAHILL</b>		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR <b>MARCH 12 1986 1:00 PM</b>	
SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b>		MD.			
10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1507 ERSKINE STREET</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARETAKER - CHURCH</b>		12b KIND OF BUSINESS OR INDUSTRY					
13a STATE <b>MD</b>		13b COUNTY <b>PR. GEO</b>		13c CITY OR TOWN <b>TAKOMA PARK</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>1507 ERSKINE ST. 20912</b>			
14 FATHER'S NAME FIRST <b>PHILIP</b>		MIDDLE <b>CAHILL</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ELLEN</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
<b>No</b>		<b>318-28-8208</b>		<b>CLAUDE CAHILL, 1507 ERSKINE ST. TAK. PC MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARCINOMATOSIS</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>June 83</b> , 19 <b>83</b> , to <b>NOW</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>MARCH 8 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Mark K Li</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>3/12/86</b>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK K LI</b>		22e ADDRESS <b>1721 UNIVERSITY BLVD W, WHEATON MD 20740</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE <b>Burial March 15, 1986</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>Dale City Cemetery</b>		23d LOCATION OF OR OWN <b>Dale City Cemetery</b>					
24 FUNERAL DIRECTOR NAME <b>Takoma Funeral Home, 254 Carroll St NW DC</b>		ADDRESS		DATE RECEIVED BY FUNERAL DIRECTOR <b>March 14, 1986</b>		TIME RECEIVED BY FUNERAL DIRECTOR <b>10:00 AM</b>					
DHMH - 16 60M 7/84 (VRA 15, 4)											

23600-00

23600-00

00-02539

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

36 08 / 54

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>BESSIE</b>	MIDDLE <b>EVELYN</b>	LAST <b>CAMPBELL</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>03 29 86</b>	2b. HOUR <b>4:20 p.m.</b>
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 21, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 yrs.</b>	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY</b>	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Virginia</b>						13b. COUNTY <b>Prince William Woodbridge</b>	
13c. CITY OR TOWN <b>Woodbridge</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Hosea</b>		MIDDLE <b>Carr</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Lucy</b>		MIDDLE <b>Ann</b>	LAST <b>Brooks</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>577 462048</b>		17. INFORMANT <b>Thomas Campbell, Dale City, Va.</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> , 19 <b>86</b> , to <b>3/29</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William Oetgen</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>29 Mar 86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. OETGEN</b>		22e. ADDRESS <b>Oxon Hill, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 2, 86</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Rhoadesville Church</b>		23d. LOCATION CITY OR TOWN <b>Rhoadesville, Orange, Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Johnson Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>3-30-86</b>		25b. REGISTRAR'S SIGNATURE <i>John Johnson Pendleton</i>			
99999999 BP DHMH - 16 60M 7/84 (VRA 15, 4)							

26350-10

RENT-A-CAR  
RICOH SERVICE



TO HOSPITAL OR PENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

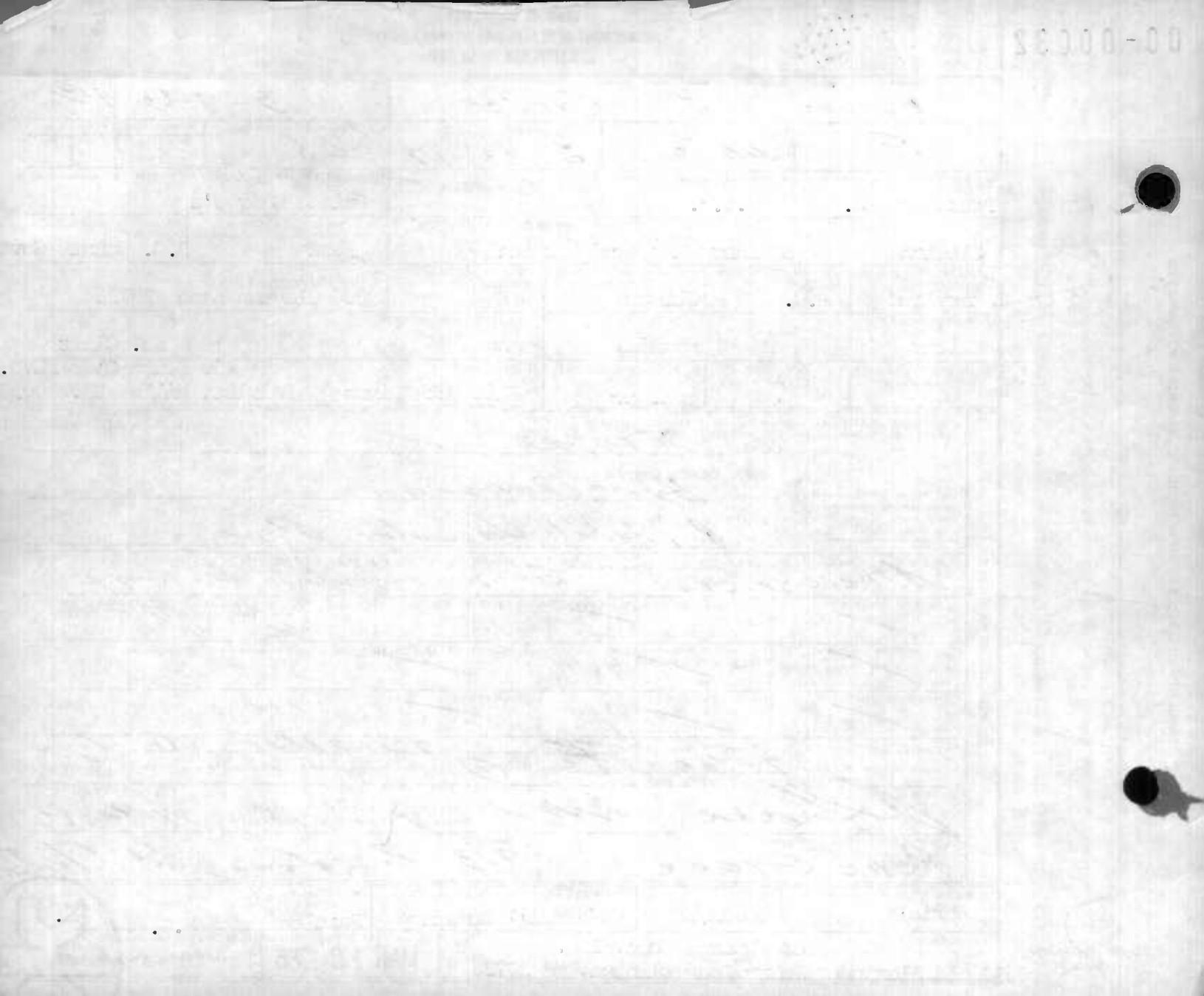
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 3 6 0 8 7 5 5		
1. FOR STATE REGISTRAR		I. DECEASED NAME FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		
1c		Florence E. Carter			3 - 7 - 86		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		2b HOUR 1 PM M	
F		White		6 23 17		6. AGE (IN YEARS LAST BIRTHDAY)	
						68	IF UNDER 1 YEAR
						YRS.	MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pittsburg PA.		U.S.A.				Prince George's MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Clinton		Southern Maryland Hospital		Clerk		P.G. County Govt	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Clinton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						13e STREET ADDRESS / ZIP CODE 8806 Clayton Lane 20735	
14 FATHER'S NAME FIRST Walter		MIDDLE Rhoades		15. MOTHER'S MAIDEN NAME FIRST Anna		LAST St. Clair	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT Elizabeth Dixon		ADDRESS 430 South Olds BLVD.	
No		N/A 579-05-1302				Fairless Hills, PA. 19030	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke							
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Peripheral Vascular Disease							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Atherosclerotic cerebrovascular Disease							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a I certify that (i) (this hospital) attended the deceased from <u>1970</u> to <u>1986</u> , that (ii) (we) last saw the deceased alive on <u>1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (do) (did not) view the body after death.							
22b SIGNATURE		22c DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED <u>Sept 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Rene Grace		913 Escatony Rd Clinton					
23a BURIAL, CREMATION, REMOVAL Burial		23b. DATE 03/12/86		23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION CITY OR TOWN Suitland	
				Cedar Hill Cemetery		COUNTY P.G.	STATE Md.
24 FUNERAL DIRECTOR NAME		Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR MAR 12 1986		25b. REGISTRAR'S SIGNATURE	
6613 Old Alexander Ferry Road Clinton, Md 20735							

SC 100-0



00-00562

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PIN 3, FEEDBACK PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

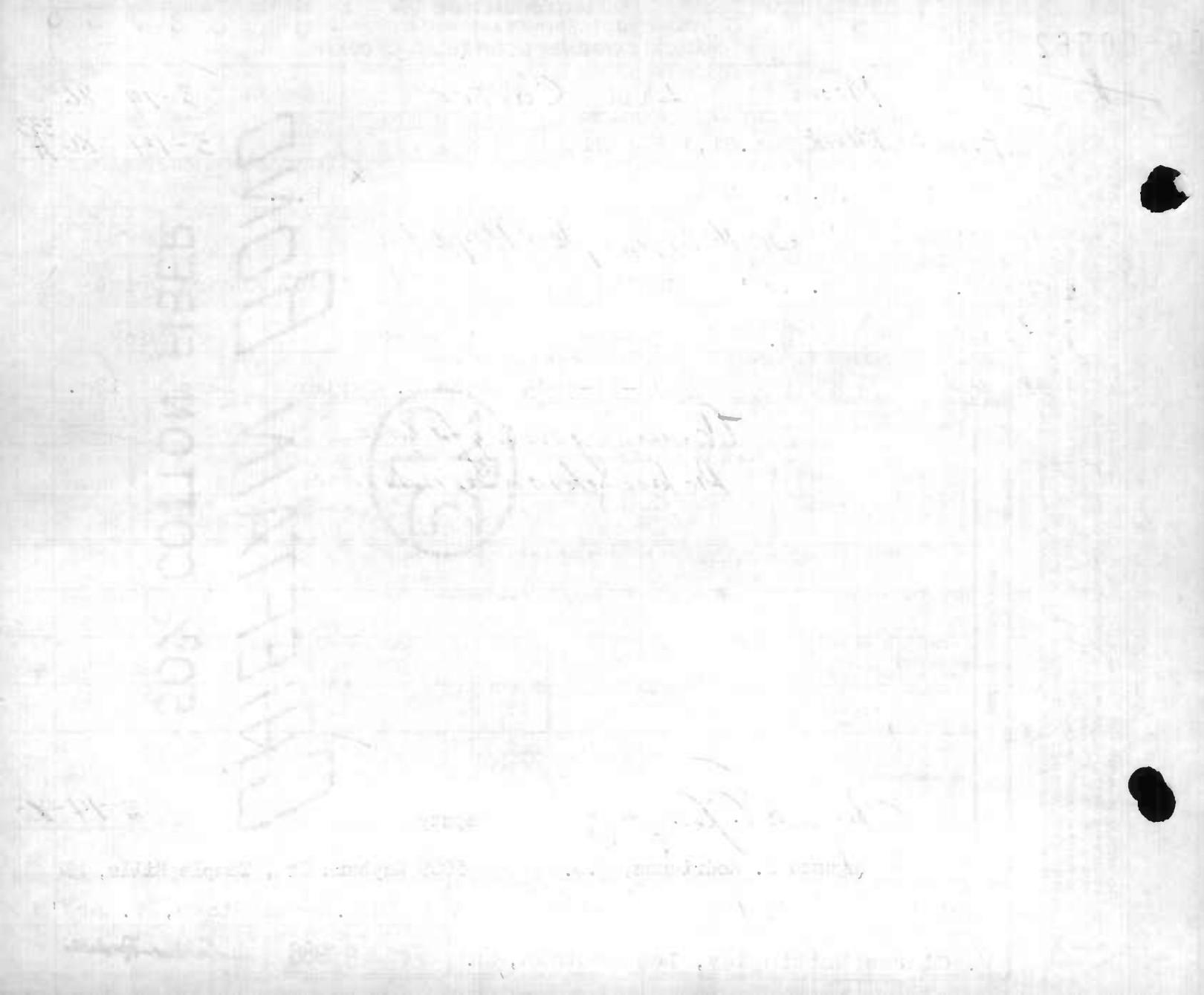
STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08/56

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Mona</i>	MIDDLE <i>Lisa</i>	LAST <i>Carter</i>	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH 3	DAY 14	YEAR 1986	2b. HOUR M		
1. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH Dec.	DAY 21	YEAR 1954	6. AGE (IN YEARS) LAST BIRTHDAY 31 YRS.	IF UNDER 1 YR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD 3-14 1986		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED WIDOWED		NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <i>P.G.</i>		
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY <i>Angora Drive</i>
13a. STATE <i>Md.</i>	13b. CITY OR TOWN <i>P.G.</i>	13c. CITY OR TOWN <i>Cheftonham</i>	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 10407 Angora Drive						
14. FATHER'S NAME FIRST <i>John</i>			MIDDLE <i>H.</i>	LAST <i>Carter</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mignonette</i>			MIDDLE	LAST	Fenwick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. 574-74-5644			17. INFORMANT John H. Carter			ADDRESS Same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Pickwickian Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER									DATE SIGNED 3-14-86	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>			ADDRESS 5009 Rayburn Ct., Temple Hills, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/19/86			23c. NAME OF CEMETERY OR CREMATORIAL Charles Memorial Gdns. Leonardtown, St. Mary's M			23d. LOCATION CITY OR TOWN			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR MAR 18 1986			25b. REGISTRAR'S SIGNATURE <i>Juliann Wilson-Kendall</i>						d
DHMH - 17 (VR A15 ME (5))												



00-0225

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 -  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>OLIVE L. CASHMAN</i>						<i>3-19-86</i>				<i>1:40 AM</i>
3. SEX FFemale		4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR <i>March 3 1914</i>			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington DC</i>		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES CO MD.</i>				
10. CITY OR TOWN OF DEATH <i>CHINTON.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>So. Maryland Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr Geo</i>	13c. CITY OR TOWN <i>Capitol Hts</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE <i>5801 Walker Mill Road 20743</i>				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
<i>John</i>		<i>Frederick</i>	<i>Reupertus</i>	<i>Josephine</i>		<i>Marie</i>		<i>Farr</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-12-3749</i>		17. INFORMANT <i>Bonnie M. Cashman</i>		ADDRESS <i>Same as #13</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recent left thumb fracture</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Acute myocardial infarction, (2) Myocardial embolus</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (the hospital) attended the deceased from <i>3/12 1986</i> to <i>3/19 1986</i> , that (I) (we) last saw the deceased alive on <i>3/18 1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.										
22b. SIGNATURE <i>Robert M Nedzbala M.D.</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>3/19/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert M Nedzbala M.D.</i>		22e. ADDRESS <i>11701 Livingston Rd Ft Washington Md</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>20 Mar 1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		23d. LOCATION CITY OR TOWN <i>Suitland, Md.</i>		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>		ADDRESS <i>Suitland, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>14 Apr 31 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Leander Randa</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial/transit permit. Then please attach the original copy to the death certificate, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **CHRONIC** it shows any injury, or other condition.

13530-00



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 5 8

0-01977

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST Ruth	MIDDLE C.	LAST Chaney	2a. DATE OF DEATH MONTH March 29, 1986	DAY YEAR 1986	2b. HOUR 9:21A M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH 8 DAY 21 YEAR 1903			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR 82 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE COUNTRY <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County</b>				
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pub. School</b>				
13e. STATE <b>MD.</b>		13c. CITY OR TOWN <b>Washington D.C.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6336 Cedar Lane 21044</b>					
14. FATHER'S NAME FIRST <b>Halsey</b>		MIDDLE <b>H</b>	LAST <b>Cady</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Lena</b>		MIDDLE		LAST <b>Woodruff</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>219-36-9969</b>			17. INFORMANT <b>Lena C. Carter</b>		ADDRESS <b>11726 Wayneridge Ave. Fulton, Md. 20759</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <b>RIGHT CEREBROVASCULAR ACCIDENT</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 h</b>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <b>ATHEROSCLEROSIS</b>								<b>Years</b>			
DUE TO, OR AS A CONSEQUENCE OF Part 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEE EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22b. I certify that (I) this hospital attended the deceased from <b>3/28</b> , 19 <b>86</b> , to <b>3/29</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/29</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22c. SIGNATURE <b>R. MAGGIN, MD</b>								22d. DEGREE <b>MD</b>			
22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22f. DATE SIGNED <b>3/29/86</b>			
23a. ADDRESS <b>14333 LAUREL BOWIE RD #307 LAUREL, MD 20708</b>											
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>4/1/86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. John's Episc. Chur</b>		23d. LOCATION CITY OR TOWN <b>Beltsville</b>		COUNTY <b>Prince George</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Borgwardt Funeral Home</b>		24a. ADDRESS <b>4400 Powder Mill Rd. Beltsville, Md. 20705</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 01 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Susan Neidson Borgwardt</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the death certificate and the burial permit. Then please remove carbon copies. Page 1 and 2 could be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Yes", any injury, or other traumatic event, in medical records, must be certified as the cause of death.

15810-00

EDISON COLOR FILM

TO HOSPITAL ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; if it is filed later, it must be signed by the attending physician.

10. FUNERAL DIRECTOR: After the certificate has been signed by the attending physician, then please remove carbon copies. Pages 1 and 2 will be filed within 24 hours after death.  
 IMPORTANT: If Item 21 is marked as "Yes" then Item 18 shows any injury or other traumatic event, the medical examiner should be notified for use in the burial permit. Then please remove carbon copies. Pages 1 and 2 will be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

11. FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Sung		Chang	March 12, 1986				2AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		Oriental		May 5 DAY 1913		72		MONTHS DAYS		HOURS MIN.	
YRS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Korea		Korea				Prince George		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
College Park		4711 Berwyn House Road		Contractor		Retired		20740			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e. STREET ADDRESS / ZIP CODE					
13b. STAFF Ma.	13b. COUNTY PG	13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4711 Berwyn House Road					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	16. ADDRESS			
Minsik				Chang	Jum		Re	Kim			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
None			218 96 8070		Wolre Chang (Wife) Same as 13E						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Adeno carcinoma of stomach 5 months.					
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause first						DUE TO, OR AS A CONSEQUENCE OF (b) metastatic cancer to liver and possibly to entire body					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a N.A.											
19a. DATE OF OPERATION N.A.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N.A. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N.A.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A.		21f. LOCATION STREET N.A.		CITY/TOWN N.A.		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1985 to March 12, 1986, that (I) (we) last saw the deceased alive on March 2, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Byoung K Lee MD						22c. DATE SIGNED 3/12/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Byoung Lee		22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				(301) 942-2676					
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 3/14/86		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION CITY OR TOWN S.S.		23e. COUNTY Mont.		23f. STATE Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi		24b. ADDRESS 11800 New Hamp. Ave. S.S.Md.		24c. DATE REC'D. BY REGISTRAR MAR 14 1986		24d. REGISTRAR'S SIGNATURE Randall					

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## Released to PMD by Medical Examiner

TO HOSPITAL OR ENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/casket permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

1 - STATE REGISTRAR

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
DINA I. CHECCHI						MARCH	14	1986	11:42AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		July 10, 1897		88		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Italy		U.S.A.				Prince George's MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Lanham		Doctors' Hospital of Pr. Geo. Co.		Homemaker		Home					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
14. STATE		15. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Silver Spring				9206 Watson Road / 20910			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
Alfredo		-		Pisani	Gismonda				Scappini		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		None		005-34-1058		Vincent Checchi (Son), Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for item 1b and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute fulminant septicemia</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute myocardial infarction</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-13, 1986, to 3-14, 1986, that (I) (we) last saw the deceased alive on 3-13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				3-14-86					
Ciro A. Montanez		5308 Dodge PK Rd - Londonderry, NJ									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		March/18/86		Calais Cemetery		Calais, Washington Co., Maine					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Chambers Funeral Home		Silver Spring, Maryland		MAR 21 1986		<i>J. Richard J. Pender</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be answered within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner can be summoned.

#### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 08 / 61
				REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST
WILLIAM LYLE CHERRY				
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	
Male		Caucasian	April 9, 1906	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Kansas		USA		
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		
Lanham		AMI Doctors' Hospital of PG County		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	
Maryland		Prince Georges	Hyattsville	
14. FATHER'S NAME FIRST		MIDDLE	LAST	
Thomas			Cherry	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT	
yes WW II		509-03-6984	Mary Ann Cherry	
18. CAUSE OF DEATH: Enter only one cause per line for part I, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Homo pericardium</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>to ruptured Myocardium</i>		
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>to Ocute D.I.</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. 22b. SIGNATURE <i>Monira Rifaat</i> DEGREE <i>M.D.</i> ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR CLINICAL LABORATORY <i>John Davidson Pendell</i> IN DATE SIGNED <i>3/14/86</i>				
22c. PHYSICIAN'S NAME Monira Rifaat, M.D., Pathologist		22d. ADDRESS AMI Doctors' Hospital of Pr. Geo. Co. 8118 Good Luck Road, Lanham, Md. 20706		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 17, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.	23d. LOCATION CITY OR TOWN Silver Spring, Maryland COUNTY STATE
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Rd. Bowie, Maryland	25a. DATE REC'D. BY REGISTRAR MAR 18 1986	25b. REGISTRAR'S SIGNATURE <i>John Davidson Pendell</i>

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基础教育研究 2011 年第 11 期

### **Table 1.**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08162					
1- STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR		
Oscar			L.			Clark, III						<input checked="" type="checkbox"/> 3-12 1986			2d HOUR 7:50 a.m.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.		
MALE			WHITE			NOV. 26, 1954			31								
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			9b. CITIZEN OF WHAT COUNTRY?									9c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9d. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
WEST VIRGINIA			U.S.A.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Laurel			Rt. 197 & Contee Rd. - in auto									LABORER			CONSTRUCTION		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RD #4 P.O. BOX 239A 15370 99999					
PENNSYLVANIA			GREENE			WAYNESBURG											
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
OSCAR LEE CLARK, JR.			NORMA JANE FOLEY														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 205-46-8730									17. INFORMANT ADDRESS					
IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
{ (b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY est. HOUR A.M. MONTH DAY YEAR ? P.M. 3-12 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject inhaled fumes from gas lantern			21d. LOCATION STREET Rt. 197 & Contee Rd., Laurel, Prince George's Co., Md.			CITY OR TOWN COUNTY STATE					
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in auto			21g. TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE Dennis F. Smyth, M.D.																	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., Md. 21201									DATE SIGNED 3-17-86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE MARCH 21, '86			23c. NAME OF CEMETERY OR CREMATORIAL PHILLIPS CEMETERY			23d. LOCATION CITY OR TOWN WAYNE TOWNSHIP, PENNSYLVANIA			25a. DATE REC'D. BY REGISTRAR MAR 19 1986					
24. FUNERAL DIRECTOR NAME			ADDRESS 8521 LOCH RAVEN BLVD.									25b. REGISTRAR'S SIGNATURE D. Larson-Randall					
WILLIAM E. JOHNSON																	

RECORDED

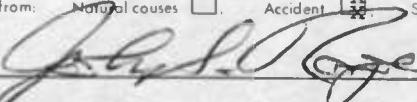
10-02362

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08/63

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-2, WITH FORM FM-3, RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 3 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. MAIL TO STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, Cremation, or Removal.

1. DECEASED NAME (TYPE OR PRINT) <b>MARVIN LOUIS COESENS</b>		MIDDLE <b>LOUIS</b>		LAST <b>COESENS</b>		2a. DATE KNOWN OF DEATH <b>MAR 28, 1986</b>	MONTH <b>APR</b>	DAY <b>28</b>	YEAR <b>1986</b>	2b. HOUR <b>11:35 AM</b>	
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 24, 1910</b>	6. AGE (IN YEARS MONTHS LAST BIRTHDAY) <b>75 yrs</b>	7. IF UNDER 1 YR. MONTHS <b>0</b>	8. IF UNDER 24 HRS. DAYS <b>0</b>	9. DATE PRONOUNCED DEAD <b>Mar. 28, 1986</b>	MONTH <b>APR</b>	DAY <b>28</b>	YEAR <b>1986</b>	10b. HOUR <b>11:35</b>	
11. BIRTHPLACE <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		14. DIVORCED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		15. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b>			
16. CITY OR TOWN OF DEATH <b>BLADENSBURG</b>		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RESIDENCE</b>				18a. USUAL OCCUPATION FOR MOST OF WORKING LIFE <b>CREDIT MANAGER</b>		18b. TYPE OF WORK <b>(Retired)</b>		18c. KIND OF BUSINESS OR INDUSTRY <b>DEPARTMENT STORE</b>	
19a. STATE <b>MD</b>	19b. COUNTY <b>PRINCE GEORGE'S</b>	19c. CITY OR TOWN <b>BLADENSBURG</b>	19d. INSIDE CITY LIMITS? <b>YES</b>	19e. STREET ADDRESS <b>4108 53RD AVENUE, APT. #4 20710</b>							
19f. FATHER'S NAME <b>Michael</b>	MIDDLE <b>Fischer</b>	19g. MOTHER'S MAIDEN NAME <b>ROSE BARBA</b>									
19h. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>	19i. SOCIAL SECURITY NO. <b>578-10-4088</b>	19j. INFORMANT <b>MARY LOU ENDRESS</b>	19k. ADDRESS <b>2608 HILLSMAN STREET FALLS CHURCH MD 22043</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Multiple Injuries</b> IMMEDIATE CAUSE (a) <b>882</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. { DOUE TO, OR AS A CONSEQUENCE OF <b>Fall</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>None</b>											
19l. MEDICAL CERTIFICATION DATE OF OPERATION <b>None</b>	19m. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11: 30 3/28/86 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell from window</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>53Rd Ave. Bladensburg Prince Georges, Md.</b>	21f. LOCATION STREET <b>53Rd Ave. Bladensburg Prince Georges, Md.</b>	CITY OR TOWN <b>Prince Georges, Md.</b>	STATE <b>MD</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>March 28, 1986</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>J. L. George</b>		19n. ADDRESS <b>1919 SEMINARY ROAD</b>		23d. LOCATION CITY OR TOWN <b>SILVER SPRING</b>		23e. COUNTY <b>MD</b>		STATE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>APR 01, 1986</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>FT. LINCOLN CEMETERY</b>									
24. FUNERAL DIRECTOR'S SON'S FUNERAL HOME NAME <b>P. A.</b>		25a. ADDRESS <b>4739 BALTIMORE AVENUE HYATTSVILLE, MD 20781</b>	25b. DATE REC'D. BY REGISTRAR <b>APR 02 1986</b>		25c. REGISTRAR'S SIGNATURE <b>Gene Gardner Pendle</b>						

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be attached to it as the burial or funeral permit. Then please remove carbon copies. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608164					
1. FOR STATE REGISTRAR			2. DATE OF DEATH MARCH 15 1986							3. HOUR 3:45A M					
1. DECEASED NAME (TYPE OR PRINT)		FIRST SALLY	MIDDLE ANN	LAST CONNELLEE	4. RACE white		5. DATE OF BIRTH MONTH Oct 31 39		6. AGE (IN YEARS LAST BIRTHDAY) 46 yrs		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. SEX female		7b. CITIZEN OF WHAT COUNTRY USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY n/a	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Friendship		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Wilson Rd 20758							
14. FATHER'S NAME FIRST Clairon		MIDDLE Earl	LAST Render	15. MOTHER'S MAIDEN NAME Mary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT Carol Randolph Connelle same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ATHEROSCLEROSIS		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
CONSTRICITIVE PERICARDITIS CHRONIC RENAL FAILURE															
20a. MEDICAL CERTIFICATION DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE JERRY B. HARMON, M.D.		22c. DEGREE MD		22d. PATHOLOGIST ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 3/15/86									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY B. HARMON, M.D., PATHOLOGIST		22g. ADDRESS Doctors' Hospital of Pr. Geo. Co. 8118 Good Luck Road, Lanham, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 3 18 86		23c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland PG Maryland									
24. FUNERAL DIRECTOR NAME Rausch Funeral Home Owings Maryland		25a. DATE REC'D. BY REGISTRAR MAR 26 1986		25b. REGISTRAR'S SIGNATURE											

30810-00



00-02518

08/65

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) <b>Melvin (NMI) Cook</b>						2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 3 - 27 1986	MONTH DAY YEAR	2b. HOUR 9 15 a.m.	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 - 3 - 28</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>57 yrs.</b>	7. IF UNDER 1 YR. MONTHS <b>0</b>	8. IF UNDER 24 HRS. HOURS <b>0</b>	9. MIN. <b>0</b>	10. DATE MONTH DAY YEAR <b>3-27 1986</b>	2d. HOUR 10 30 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1703 East West Highway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Maintance</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS <b>20783 East West Highway</b>					
14. FATHER'S NAME FIRST <b>Henry</b>		MIDDLE <b>Cook</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Dorothy</b>		MIDDLE	LAST <b>Lane</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>223-40-7607</b>		17. INFORMANT ADDRESS <b>2600 22ND Street N.E.</b>		Washington, DC			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  (b) <b>Adenocarcinoma of Sigmoid Colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic disease of liver and lung</b>									
19a. DATE OF OPERATION <b>1/23/86</b>									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Palliative Sigmoid colectomy for part. obst.</b>									
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>J. E. Glancy III, M.D.</i>									
TITLE (SPECIFY) <b>M.D.</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>John E. Glancy III, M.D.</b>									
ADDRESS <b>733 Cloverly St. Sil. Spg. Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-5-1986</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Morris Bapt Ch. Cem.</b>		23d. LOCATION CITY OR TOWN <b>Hume</b>		COUNTY <b>Fauquier</b>	STATE <b>VA</b>
24. FUNERAL DIRECTOR NAME <i>Erie L. Dyer</i>		ADDRESS <b>P.O. Box 397 Purcellville, VA 22132</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 8 1986</b>		25b. REGISTRAR'S SIGNATURE <i>J. Glancy, M.D.</i>			
BP _____		DHHM - 17 (VR A15 ME (5)) 20M 4/B2							

9-17591-00

00-00875

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8608166

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<u>Irene</u>			<u>H</u>	<u>Costello</u>		<u>3</u>	<u>10</u>	<u>86</u>	<u>4:35 P.M.</u>			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR		
Female		White		MONTH	DAY	YEAR	91	YRS	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Missouri		U.S.A.						Prince George's				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Adelphi		Presidential Woods Nursing Hm			Housewife			Domestic				
13a. STATE IN COUNTY						13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland Montgomery Silver Spr										15062 Haselmere Ct. 20906		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS			
Thomas				Myria					Greer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		444-03-7728			Roy Graham			5 days				
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Detox w/ chronic CW Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Organic Brain Syndrome</u> (c) <u>2 wks</u> <u>years</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10/86</u> to <u>3/11/86</u> , that (I) lost saw the deceased alive at <u>1975</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.												
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			<u>C. H. L. Igam Jr.</u>			<u>3/10/86</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Removal		3-10-86		Georgetown Med School			Washington,		D.C.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Columbia Mortuary Services					MAR 18 1986			John Davidson-Pandelle				
225 Missouri Ave, NW Washington, DC 20011												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy of pages 1 and 2 which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, in medical examination and/or autopsy report, attach a copy hereto.

BP \_\_\_\_\_

928.01.2 Water? 14 1921

Flower Hill 22° S

2000 ft.

Soil - yellowish brown

00-01767

STATE OF MARYLAND

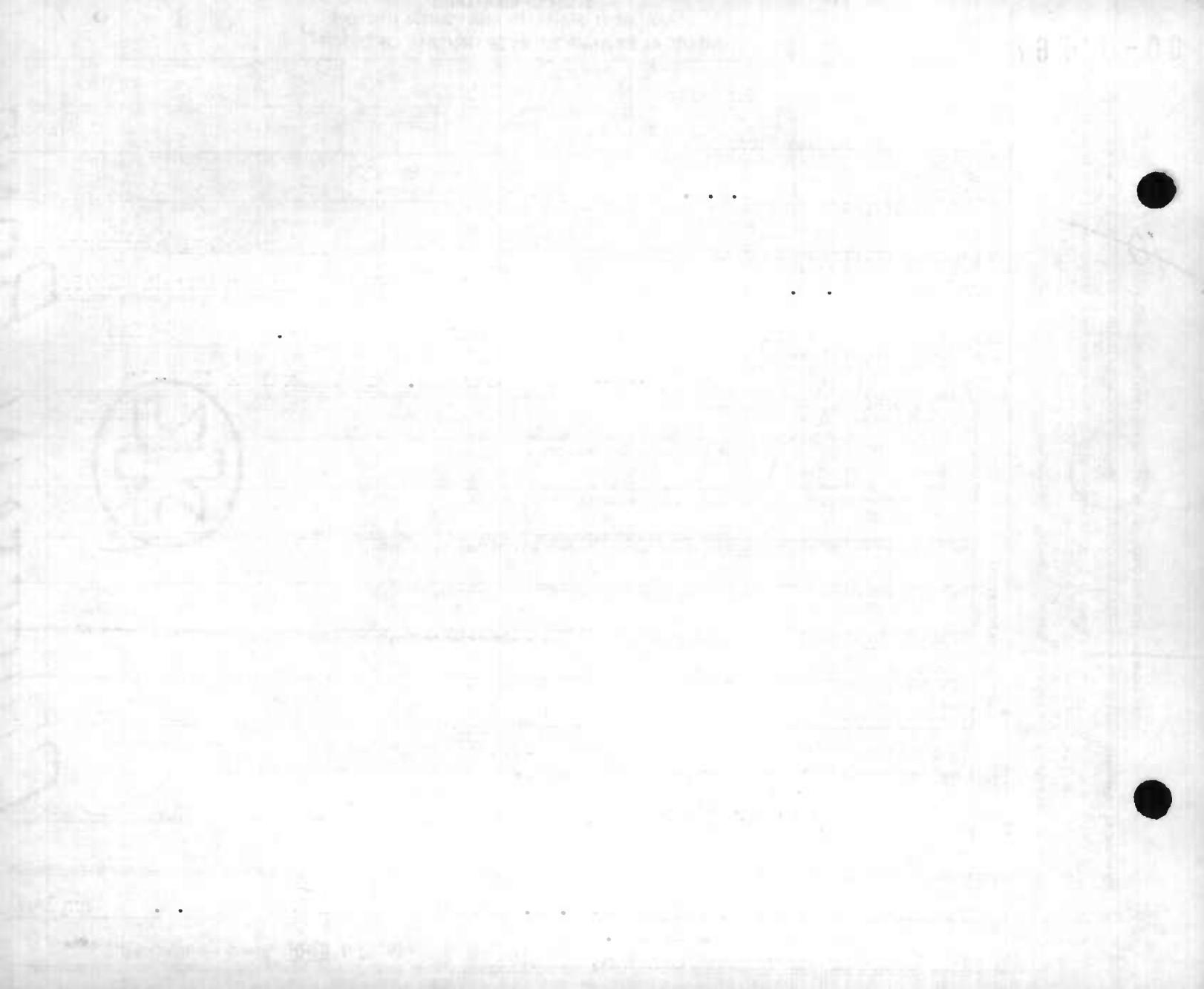
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08/16/

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARK	MIDDLE Anthony	LAST COSTELLO	2e. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 3	DAY 19	YEAR 1986	2b. HOUR M		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 7, 1967	6. AGE (IN YEARS LAST BIRTHDAY) 19 yrs.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD 3 19 1986	2d. HOUR 10:43 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County			MD.		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) auto-11000 Thrift Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Specialist			12b. KIND OF BUSINESS OR INDUSTRY Private			
13a. STATE Maryland	13b. COUNTY P. G.	13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> XX	13e. STREET ADDRESS 11416 Hermitt Street 20735						
14. FATHER'S NAME FIRST Edgar		MIDDLE Joseph	LAST Costello	15. MOTHER'S MAIDEN NAME FIRST Carol			MIDDLE A.	LAST Wise			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Carol A. Stahl			ADDRESS Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <input checked="" type="checkbox"/> 3-19- 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) auto		21f. LOCATION STREET 11000 Thrift Rd., Clinton, Prince George's, MD	CITY OR TOWN	COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.										DATE SIGNED 3-19-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Lee F. H. Crematory			23d. LOCATION CITY OR TOWN Clinton		COUNTY P.G.	STATE Maryland	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR MAR 27 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson						
6633 Old Alexander Ferry Road Clinton, Md 20735											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

08 / 68

00-00568

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME <b>ETHEL M. COX</b>			2d. DATE OF DEATH <b>03-15-86</b>	MONTH YEAR	DAY	2b. HOUR <b>1:15PM</b>				
			3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>May 21 1906</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b>			MD.		
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Riverdale</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>6618 Patterson St. 20737</b>				
14. FATHER'S NAME FIRST <b>Thomas</b>			MIDDLE <b>F.</b>	LAST <b>Allen</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			LAST <b>DuVaughn</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-84-2749</b>			17. INFORMANT <b>Elizabeth E. Wesley Riverdale, Md.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>	
18. CAUSE OF DEATH (Enter only one cause per line for item 18b, and indicate if death was caused by: PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>315</i>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I/We) attended the deceased from <i>3/15 1986</i> to <i>3/15 1986</i> , that (I/We) last saw the deceased alive on <i>3/15 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did not) view the body after death.										
22b. SIGNATURE <i>George Jaffre, MD</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>3/16/86</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George Jaffre, MD</i>		22f. ADDRESS <i>7500 Hanover Pkwy Greenbelt</i>								
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>3/19/86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Suitland</b>		23e. COUNTY <b>P.G. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		ADDRESS <b>Oxon Hill Rd. Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>Mar 18 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Pender</i>				

10. HOSPITAL OR ATTENDING PHYSICIAN:  
Required by the Hospital or attending physician.11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered to us at the funeral home. Then please remove carbon paper. Page 1 and 2 must be filed within 72 hours after death.  
IMPORTANT: If item 21 is marked as having any injury, an other traumatic event, the physician must sign this page.

95 DOI 10.1186/s13059-016-0935-0

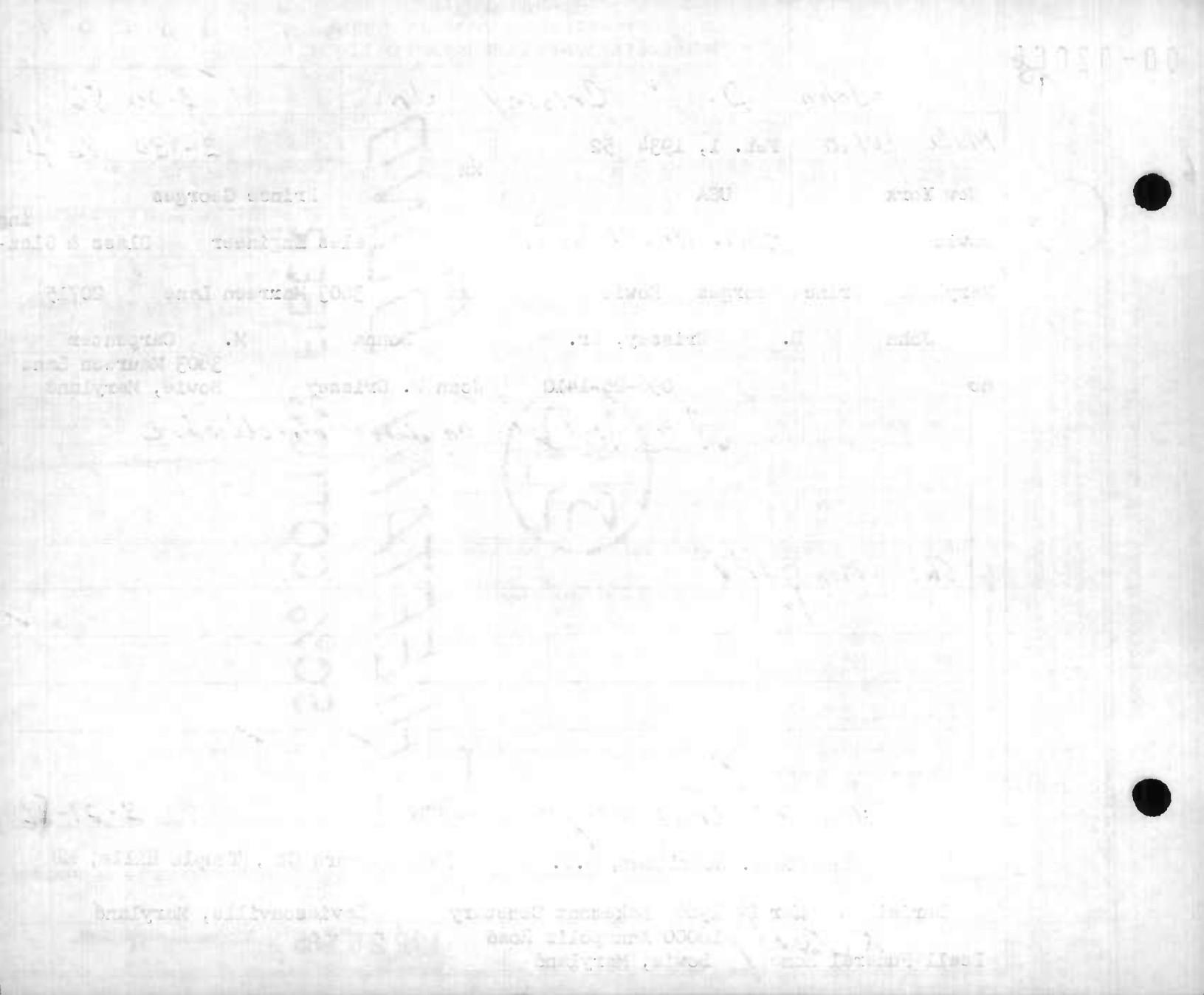
• 0.01 • 0.1 • 1 • 10 • 100 • 1000 • 10000

• 52 committed older  
• 53 established younger. Estimated CAT - 112

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, PERTAINING TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00 - 02066 0 8 / 6 9				
1 - STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR				
			John D. Crissey Jr.						<input type="checkbox"/> 3-20 1986			M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR 24 HOUR	
Male		White		Feb. 1, 1934		52 yrs.						3-30 1986			P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?						MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York			USA						WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Prince Georges			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bowie			Bowie Health Center						Sales Engineer			Glass & Glaz-ing				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Prince Georges		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3603 Maureen Lane 20715						
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
John			D.		Crissey, Sr.		Donna			M.			Carpenter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS				
no			096-26-1410						Joan W. Crissey			3603 Maureen Lane Bowie, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Aspiration of food</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER																
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 5009 Rayburn Ct, Temple Hills, MD						DATE SIGNED 3-21-86							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Mar 24 1986			23c. NAME OF CEMETERY OR CREMATORIAL Lakemont Cemetery			23d. LOCATION CITY OR TOWN Davidsonville, Maryland			COUNTY STATE				
Burial																
24. FUNERAL DIRECTOR NAME			16000 Annapolis Road						25a. DATE REC'D. BY REGISTRAR MAR 26 1986			25b. REGISTRAR'S SIGNATURE				
Beall Funeral Home			Bowie, Maryland													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENcil IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-1, REURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08/10		
												REG. NO.		
1. DECEASED NAME (TYPE OF PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF EST. DEATH MATED			MONTH	DAY	YEAR	2b HOUR		
<i>Arthur Webster Cummings</i>						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3-12	86	86	86		
3. SEX <i>Male</i>			4. DATE OF BIRTH MONTH DAY YEAR	5. AGE (IN YEARS LAST BIRTHDAY)	6. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
			August 4, 1914	71 RS.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	3-12	1986	10	MD		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY: <i>New York</i>			7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>			MD.		
10. CITY OR TOWN OF DEATH <i>Temple Hills</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STATE AND ADDRESS <i>4704 23rd Parkway Apt. 7 Retired Gov'T</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Operator</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>20748</i>					
13a. STATE <i>MD.</i>			13b. COUNTY <i>P.G.</i>			13c. CITY OR TOWN <i>Temple Hill</i>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS <i>4704 23th Parkway #7</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick Cummings</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Pansy Brunson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> YES (IF YES, GIVE WAR OR DATES) <i>WWII</i>			16b. SOCIAL SECURITY NO. <i>NOT STATED</i>			17. INFORMANT ADDRESS <i>Terance Cummings Son Same as 13e</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
									<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> TITLE (SPECIFY) Deputy MEDICAL EXAMINER														
DATE SIGNED <i>3-12-86</i>														
EXAMINER'S NAME (TYPE OF PRINT) <i>Augusto P. Rodriguez, M.D.</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>17 March 86</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Cheltenham Nat'L Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Cheltenham, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Frazier's Funeral Home</i>			ADDRESS <i>389 Rhode Island Avenue</i>			25a. DATE REC'D. BY REGISTRAR <i>PR 03 1986</i>			25b. REGISTRAR'S SIGNATURE <i>J.ie Davidson-Randall</i>					
BP _____														
DHMH - 17 (VR A15 ME (5))														

00-01668

RECORDED BY TELETYPE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the Burial/Transit Permit. Then please remove carbon paper. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 6 0 8 / 7 1			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Helene W. Davis						3-30-1986			8.30 PM				
3. SEX F.		4. RACE Caucasian W.		5. DATE OF BIRTH MONTH DAY YEAR 4 - 15 - 04			6. AGE (IN YEARS LAST BIRTHDAY) 88 81 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Waterbury, Conn		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.						
10. CITY OR TOWN OF DEATH Mitchellville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE MD		13b. COUNTY 2806 Folsom Ln.		13c. CITY OR TOWN Bowie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2806 Folsom Lane 20715			
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Whitney		15. MOTHER'S MAIDEN NAME Anne Burns											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 041-16-1876		17. INFORMANT Rev: Anthony Dal Balcon-3800 Lottsford Vista Rd. Mitchellville MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Pneumonia</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Paroxysm's Disease</u>										75 yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>congestive heart failure</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY, YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> , 19 <u>83</u> , to <u>3/30</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/26/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Bruce Cooper</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>3/30/86</u>								
22e. ADDRESS <u>6525 Belcrest Rd Hyattsville, md</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 2 1986		23c. NAME OF CEMETERY OR CREMATORIAL Lakemont Cemetery			23d. LOCATION CITY OR TOWN Davidsonville, Maryland		23e. COUNTY Maryland			23f. STATE	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Rd. ADDRESS Bowie, Maryland			25a. DATE REC'D. BY REGISTRAR APR 01 1986			25b. REGISTRAR'S SIGNATURE <u>John Davidson - Linda</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked  there was any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8008772			
1 - STATE REGISTRAR			2a. DATE OF DEATH MARCH 17, 1986							2b. HOUR 10:10AM			
1. DECEASED NAME FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR										
WILHELMINA S. DAVIS			JAN. 1, 1904							6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS DAYS		
3. SEX FEMALE			8. CITIZEN OF WHAT COUNTRY? U.S.A.							9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY GEORGIA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										
10. CITY OR TOWN OF DEATH LARGO			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE N. H. 600 LARGO RD.							12a. USUAL OCCUPATION RET. CLERK		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.	
13a. STATE Md.			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 704 N. PAYSON ST. 21217			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
WILLIAM GRAY			IDA CRAWFORD										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 223-09-5940							17. INFORMANT ADDRESS 5909 CLAY ST. N.E. WASHINGTON, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis, Immunocompromised, State</u> (b) <u>Rectal Carcinoma, Malnutrition.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.							21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)							21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10/86</u> to <u>3/17/86</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <u>Stuart J. Turkewitz, M.D.</u>			22c. DEGREE M.D.							22d. DATE SIGNED <u>3/17/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart J. Turkewitz, M.D.			22e. ADDRESS 7500 Greenway Center Drive Greenbelt, Maryland 20770										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-18-1986			23c. NAME OF CEMETERY OR CREMATORIAL ARBITUS MEMORIAL PARK				23d. LOCATION CITY OR TOWN BALTIMORE, BALT.CO. Md.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.			ADDRESS RIVERDALE, Md. 20737							25a. DATE REC'D. BY REGISTRAR MAR 20 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson Kendall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on the body, show my injury, or other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 8 1 7 3			
										REG. NO.			
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Martha (mn) Dawson						3 25 86			2:25 P.M.				
SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR				
FEMALE		CAUCASIAN		2 16 01			85		MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		IF UNDER 24 HRS.				
IRELAND		USA					Prince George's Co. MD.		MONTHS HOURS MIN.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel		Greater Laurel Nursing Home								Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Md.		P.D.		Cheverly					3115 BELLEVUE AVE. 20785				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								ADDRESS			
Richard Ruthledge		Catherine Maria McNally								12610 CEDAR Brook Ln			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO; IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.								17. INFORMANT		Barbara Marcinko Laurel, MD. 20708	
No —		577-42-4378											
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Caudopulmonary arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiovascular accident</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> 19 <u>86</u> to <u>Present</u> 19 <u>      </u> , that (I) (we) last saw the deceased alive on <u>3/7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>John W. Goss III</u>		DEGREE								22c. DATE SIGNED 5/25/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>L. CARAS III</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/25/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>FT Lincoln Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Brentwood</u> COUNTY <u>P.G.</u> STATE <u>MD.</u>						
24. FUNERAL DIRECTOR NAME <u>FLECK F.H. INC.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 31 1986</u>		25b. REGISTRAR'S SIGNATURE <u>India Davidson-Randall</u>									

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00-00811

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08/74

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
FRANK W DELAHANTY							MAR	8	86	1:20 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		White		Month Day Year		57 YRS		Months Days		Hours Min	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		United States				Prince Georges					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
AAFB		Malcolm Grow Medical Center		Electrician		USGov't					
13a. STATE 13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Charles		Charlotte Hall		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt #1 Box 18		20622	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS				
		Frank	W	Delahanty	Dorothy		26184 Hillsbord				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for Part I) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		077-22-4955		Frank W Delahanty III		PLACE El Toro Ca					
18. CAUSE OF DEATH (Enter only one cause per line for Part I) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				20. DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL DAMAGES							
				(c) DUE TO, OR AS A CONSEQUENCE OF HYPOXIA FROM SEIZURES							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				21c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8 March 1986 to 8 March 1986, that (I) (we) last saw the deceased alive on 8 March 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
Timothy Ladner		MD				8 March 86					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS		22h. LOCATION							
TIMOTHY LADNER				Malcolm Grow Medical Center AAFB Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION					
Burial		11 Mar 1986		Arlington National		Arlington					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert E. Wilhelm Funeral HOME											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be furnished for use by the burial or cremation firm. Then please remove from papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is checked as "No" the medical examiner must be notified on this form.

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## TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/Funeral permit. Their please remove this paper, pages 1 and 2 should be filed with 22 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 6 0 8 / 7 5	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Julia F. DESARNO							03	10	86		3:32 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		Sept 6, 1920			65 yrs.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		United States					PRINCE GEORGES						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton				Southgreen md Hospital				cafeteria worker			PG Bd of Education		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Pr George		Forestville				2708 Phelps Ave			20747		
14. FATHER'S NAME FIRST				MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST	
John						Rawlings	Myrtle					Windsor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No				--			Ralph F DeSarno			Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary embolus</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>56 hr.</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes mellitus - hypertension</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									<input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 79, to _____, 19 86, that (I) (we) lost saw the deceased alive on _____, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J. Donald Young</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>3/10/86</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. S. Young M.D.</i>			22f. ADDRESS <i>11701 Livingston Rd. Ft. Wash. Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-12-86			23c. NAME OF CEMETERY OR CREMATORIAL REsurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton COUNTY PG STATE Md				
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home			ADDRESS Suitland, Md.			25a. DATE REC'D. BY REGISTRAR MAR 17 1986			25b. REGISTRAR'S SIGNATURE <i>Janet Wilson-Pearce</i>				
DHMH - 16 50M 4/83 (VRA 15, 4)													

05.100-00

071070

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 7 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

I DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
WILLIAM				E	DILLOW	FEBRUARY, 28	1986	11:15M			
3. SEX <input checked="" type="checkbox"/> Male		4 RACE <input checked="" type="checkbox"/> White		5. DATE OF BIRTH MONTH 4 DAY 18 YEAR 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <input checked="" type="checkbox"/> W. Va.		7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		MD.			
10. CITY OR TOWN OF DEATH <input checked="" type="checkbox"/> Suitland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <input checked="" type="checkbox"/> Andrews Air Force Base				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <input checked="" type="checkbox"/> U.S. Air Force		12b KIND OF BUSINESS OR INDUSTRY 999999			
13a. STATE <input checked="" type="checkbox"/> Delaware		13b. COUNTY <input checked="" type="checkbox"/> Kent		13c. CITY OR TOWN <input checked="" type="checkbox"/> Dover		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET ADDRESS / ZIP CODE <input checked="" type="checkbox"/> 24 N. Halsey Road			
14. FATHER'S NAME FIRST <input checked="" type="checkbox"/> Harry		MIDDLE <input checked="" type="checkbox"/> Dillow		LAST <input checked="" type="checkbox"/> Dillow		15. MOTHER'S MAIDEN NAME <input checked="" type="checkbox"/> Viola		MIDDLE LAST Dillow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <input checked="" type="checkbox"/> 1945-1971		16c. GURMAN <input checked="" type="checkbox"/> wife		16d. ADDRESS 24 N. Halsey Rd.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
16e. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>		(b) <u>Hypertensive CA</u>				(c)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
22a. INJURY OCCURRED <input checked="" type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22b. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22c. SIGNATURE <u>Mark Rollo</u> (ATTENDING PHYSICIAN'S NAME, TYPE OR PRINT)						DEGREE <input checked="" type="checkbox"/> AP Resident		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <input checked="" type="checkbox"/> Burial						23b. DATE March 3, 86		23c. NAME OF CEMETERY OR CREMATORIAL Sharon Hill Park		23d. LOCATION CITY OR TOWN Park Dover COUNTY Kent STATE Delaware	
24. FUNERAL DIRECTOR NAME <input checked="" type="checkbox"/> Pauline Paulinehill						ADDRESS Golf Club Dover Del.		25a. DATE REC'D. BY REGISTRAR MAR 05 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton	
999999 BP						Maryland Lic 0100438					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use in the burial/transept period. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608171				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		03 13 86		12:50AM			
LAURA E DOLAN														
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Female			caucasian		March 24 1905		80							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		PRINCE GEORGE (MD.)					
Virginia			USA											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
CLINTON			Southern Md Hospital							Cleaning woman			Bank	
13a STATE Md.			13b COUNTY P.G.		13c CITY OR TOWN Clinton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 309 Mecca Ct.		20744			
14. FATHER'S NAME FIRST Woodford			MIDDLE H.		LAST Sirles		15. MOTHER'S MAIDEN NAME FIRST Laura		MIDDLE		LAST Pugh			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. -----		16c		17 INFORMANT		ADDRESS					
			220-28-7435				Laurel L. Montagne same as 13e							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
CONGESTIVE HEART FAILURE														
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
PNEUMONIA														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/13 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b SIGNATURE: <i>A. Nachani</i>			DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/13/86			
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS									
G. NACHANI. M.D.					8926 Woodyard Rd., CLINTON, MD									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial			3/15/86		Md. Nat'l Memo.Pk.		Laurel		P.G.		Md.			
24. FUNERAL DIRECTOR NAME			24a. ADDRESS		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE							
FLECK F.H. INC.			1601 Sandy Spring Rd.		Laurel, MD. 20707		MAR 17 1986		<i>John Pendell</i>					

12400-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon copy of page 3 and file within 72 hours after death.

IMPORTANT: If item 21 is marked or item 22 above shows any injury, another physician's opinion must be secured from the medical examiner before the certificate can be filed.

00-02282

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0  
REG NO 08778

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Mary	Lovella	DOWNING	March		22	1986	1:20am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
Female		White		Sept 9, 1897		88		IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ohio		USA				Prince George					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Lanham		Doctors Hospital of PG Cty		Housewife		Own home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20746	
Maryland		Pr Geo		Suitland		YES <input type="checkbox"/>		5020 Silver Hill Ct #101			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE		LAST		
		Andrew		Winnie	Anna				Winter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		577-48-9189		Helen Shepherd		Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>pneumonia, right lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), if any, which gave rise to underlying cause (b), if any, which gave rise to underlying cause (c).  DUE TO, OR AS A CONSEQUENCE OF (b) <i>septic shock.</i> (c) <i></i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) this hospital attended the deceased from <i>3/22</i> , 19 <i>86</i> , to <i>3/22</i> , 19 <i>86</i> , that (I) last saw the deceased alive on <i>3/22</i> , 19 <i>86</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.											
22b. SIGNATURE <i>R. Chasoff MD</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <i>3/22/86</i>											
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		<i>T. Chasoff MD</i>		22d. ADDRESS <i>8824 Cunningham Drive</i>		22e. LOCATION <i>Falls Church, Bernay Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL METHOD		23b. DATE <i>24 Mar 1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>National Mem Park</i>		23d. LOCATION <i>Falls Church, Bernay Hospital</i>					
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>		ADDRESS <i>Suitland, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAK 31 1986</i>		25b. REGISTRAR'S SIGNATURE <i>MAK</i>					
DHMH - 16 60M 7/84 (VRA 15, 4)											

CONFIDENTIAL INFORMATION FOR MEDICAL AND VETERINARY USE  
NANCY HISTORY  
(Delete each section)

	BIRTH WEIGHT	MOTHER'S NAME AND ADDRESS
	-2381 GRAMS	Miss Nancy H
	OR	2304 Ocala
	5 LBS. 4 OZS.	Baltimore, Ma
dead	14d. Before 20	14e. After 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **(X)**, show any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608179	
										REG. NO.	
1 - FOR STATE REGISTRAR			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
1. DECEASED NAME <i>JOHN A DRURY</i>						3-28-86			12:33 A		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 2 DAY 13 YEAR 1915			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		White									
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.				
Maryland		U.S.A.									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
CLINTON		SOUTHERN MARYLAND HOSPITAL CENTER					Carpenter Self Employed				
13a STATE Maryland		13b COUNTY P.G.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 3300 25th Ave. 20748				
14 FATHER'S NAME First: Theodore		Middle: Drury		15 MOTHER'S MAIDEN NAME Anne			MIDDLE LAST			Shuffler	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 577-14-1010		17 INFORMANT Elizabeth H. Drury			ADDRESS as in item 13e			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE
22a I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>June</u> , 19 <u>83</u> , to <u>March 28</u> , 19 <u>86</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>March 27</u> , 19 <u>86</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b SIGNATURE <i>flw</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 3/28/86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>PHILIP WISOTSKY</b>		22e ADDRESS <b>6188 OXON HILL RD OXON HILL, MARYLAND</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <b>3-31-86</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>Resurrection Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Clinton</b>		COUNTY <b>P.G.</b>	STATE <b>Md.</b>	
24 FUNERAL DIRECTOR NAME <b>G.P.KALAS</b>		ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>			25a. DATE REC'D. BY REGISTRAR APR 01 1986 25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Rendell</i>						

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3300 25TH ST. N.E. WASHINGTON, D.C.

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• 100% of the energy consumed by the U.S. electric power sector is derived from fossil fuels.

10

$\Sigma$  does not exist.

7

CHIN MOTO CO LTD CHINA 6556

-34-<sup>80</sup> *Resumption of the Committee on Safety*

54. His sex is His sex Octo Bala. I.D.

00-01840

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH08/80  
REG. NO.1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE KNOWN OF EST. DEATH MATED	XX MONTH	DAY	YEAR	2b HOUR	
Dale E. Duckett							<input checked="" type="checkbox"/>	3-16	19	86	M	
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
M	Black	05 12 '61	24 yrs.				<input type="checkbox"/>	3-16	19	86	p. m. 11:18	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Prince George's County, MD.					
10. CITY OF TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY
Clinton		Southern Maryland Hospital - DOA										
13. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Charles		Waldorf		<input checked="" type="checkbox"/>		2646 Hamilton Place 20601				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS					
Thomas		D.		Duckett	Edna		L. Porter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
YES 180-'84		214-88-1912		Edna Duckett		SAA						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8151												
IMMEDIATE CAUSE (a) Craniocerebral Trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 9:20PM 3-16 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in pick-up truck/fixed object		YES <input type="checkbox"/> NO XX						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET 11904 Gallahan Rd., Oxon Hill, Prince George's CITY OR TOWN COUNTY STATE impact Co. Md.								
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE Lewis Dugay, M.D.		TITLE (SPECIFY) MEDICAL EXAMINER					DATE SIGNED					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 20 Mar 86		23c. NAME OF CEMETERY OR CREMATORIUM Gibson's Un. Meth. Ch.		23d. LOCATION CITY OR TOWN Brandywine, P.G., Md.		COUNTY STATE				
24. FUNERAL DIRECTOR NAME Martel Adams, Aqua co Md		ADDRESS 60608					25a. DATE REC'D. BY REC'D. MAR 27 1986					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed within 72 hours after death.

should be detached for use as the burial/transit permit. Then please remove carbon duplicate, sign 1 below &amp; attach to the original.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, check here if you would like to be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 6 0 8 / 8 1
1 - DECLARED NAME <b>William Frank Dunker</b>			2a. DATE OF DEATH <b>March 25, 1986</b>	2b. HOUR <b>9:40 P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>August 16, 1898</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>	IF UNDER 1 YEAR MONTHS <b>YRS</b> DAYS	IF UNDER 24 HRS MONTHS <b>HOURS</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Magnolia Gardens Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Insurance Adjuster</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Fred Bunting CO.</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Lanham</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>6824 Riverdale Road 20706</b>	
14. FATHER'S NAME <b>William</b>	MIDDLE <b></b>	LAST <b>Dunker</b>	15. MOTHER'S MAIDEN NAME <b>Emma</b>	MIDDLE <b></b>	LAST <b>Rolf</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>579-30-1913</b>	17. INFORMANT <b>Mrs. Doris A. Smith</b>	ADDRESS <b>7213 Kidmore Lane Lanham, Md. 20706</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b>					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>RENAL FAILURE</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>8-8-1987</b> to <b>3-25-1986</b> , that (I) (we) last saw the deceased alive on <b>3-9-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Virender P. Singh</i>	22c. DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <b>March 27, 1986</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Virender P. Singh, M.D.</b>	22e. ADDRESS <b>5632 Annapolis Rd. #9-Bladensburg, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>March 28, 1986</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Suitland</b>	COUNTY <b>P.G.</b>	STATE <b>Maryland</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>	25a. DATE REC'D. BY REGISTRAR <b>APR 02 1986</b>			25b. REGISTRAR'S SIGNATURE <i>Franklin Pendleton</i>	
DHMH - 16 60M 7/84 (VRA 15, 4)					

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Page 7 of 7

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

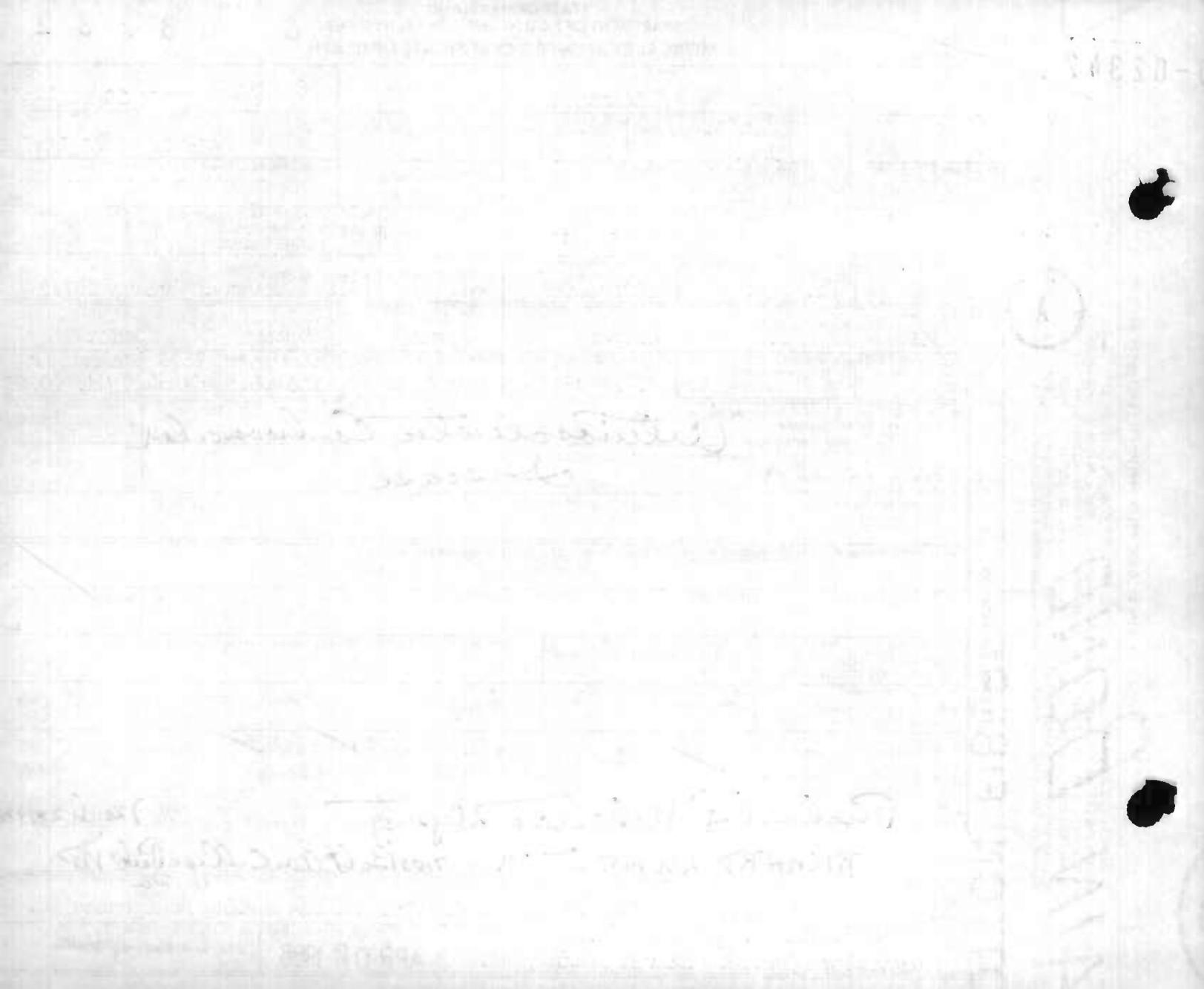
**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1-2 AND 3 TO THE FUNERAL DIRECTOR.

**TO MEDICAL EXAMINER:** PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM B-1A, ORNATE CROWN PAGE 5 AND YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 & 5 SHOULD BE FILED WITHIN 72 HOURS OF THE DEATH. WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PINTON STREET, BALTIMORE, MARYLAND, 21201 FOR BURIAL, CREMATION, OR REMOVAL.

PRINTED IN BEIJING 2011 W PESSIMON IS EDITION NO. 21291

DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		X MONTH DAY YEAR		2b. HOUR		
RUTH		Elizabeth		DYKES		<input checked="" type="checkbox"/>		MARCH 28 86		12:50 P.M.		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH - <b>09</b> - 09 YEAR <b>Jan.</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY</b>				
10. CITY OR TOWN OF DEATH <b>LAUREL</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BELTSVILLE HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>				12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Beltsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13120 Greenmont Avenue 20705</b>							
14. FATHER'S NAME FIRST <b>James</b>		MIDDLE <b>E.</b>	LAST <b>Hodges</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Agnes</b>		MIDDLE <b>Louise</b>	LAST <b>Bauer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>577-20-9566</b>		17. INFORMANT <b>Daughter</b>		ADDRESS <b>2603 Lackawanna</b>						
				<b>Elizabeth J. Fattorini Adelphi, Md. 20783</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Richard L. Whetton</i>	TITLE (SPECIFY) <i>M.D. Deputy</i> MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) <b>RICHARD L. WHETTON</b>	DATE SIGNED <i>March 28/92</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Apr. 1, 1986</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Silver Spring</b>		COUNTY <b>Montgomery</b>		STATE <b>Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins, Jr.</b>	ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 02 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Jeanne Dawson-Rendell</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a practicing physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then have removed carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 0 8 / 8 3			
												REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			3 2 86			4:43 P.M.			
MARTHA BARROWS EISENACHER,															
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female			White			Sept. 19, 1907									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Pennsylvania			United States			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham			Doctor's Hospital of PR. George Co.									Housewife		at home	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Charles Co.		Waldorf						3017-Prince Albert Sq. 20601				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
William Blanchard Barrows			Clara Gertrude Howard												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT		20715	
No			212-26-3168									M. Kent Barker (Son)		12404-Winding Lane, Bowie, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Concremation of lung</i> (c) <i>Congestive failure</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this) attended the deceased from 86-2-1986 to 31-2-1986, that (I) (we) last saw the deceased alive on 19-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>Barry Rosenberg MD</i>			22c. DEGREE									22d. DATE SIGNED March 3, 1986			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS												
Barry Rosenberg, MD			6501-Landover Rd., Cheverly, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3-3-1986			23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory			23d. LOCATION CITY OR TOWN Washington, District of Columbia			COUNTY STATE			
24. FUNERAL DIRECTOR NAME J.Wm.Lee's Sons Co.			25a. DATE REC'D. BY REGISTRAR ADDRESS 300-4th St., NE, Wash., DC 20002									25b. REGISTRAR'S SIGNATURE <i>J.Wm.Lee's Sons Co. 300-4th St., NE, Wash., DC 20002 MAR 12 1986</i>			

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## Classification

your new place! 225 S. 3rd Street

<sup>20</sup> See also K. L. Gentry, *God's War: The Religious Roots of Democracy* (New Haven, 1993).

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, medical examination should be done at once.

00-00932

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 08 / 84

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>MILDRED F. EUSERIO</i>						<i>3-17-86</i>				<i>5:35 AM</i>	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						
Female	White	<i>April 7 1934</i>			51						
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
So Carolina		USA				<i>PRINCE GEORGES COUNTY</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
<i>CHINTON</i>		<i>SOUTHERN MARYLAND HOSPITAL</i>			<i>Ex Secretary</i>					<i>Maintenance</i>	
13a. STATE		13b. COUNTY	14. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			20744		
Maryland		Pr Geo	Ft Washington			2602 Brinkley Road #216					
14. FATHER'S NAME		MIDDLE	15. MOTHER'S MAIDEN NAME								
<i>Arthur</i>		<i>Flowers</i>	<i>Rebecca</i>							<i>Herring</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		<i>248 50 8337</i>		<i>Rebecca J Hinkle</i>		<i>Capitol Hgts, Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Metastatic Squamous Cell Lung Cancer</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		{ (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 19 85</i> to <i>March 19 86</i> , that (I) (we) last saw the deceased alive on <i>March 16 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22b. DATE SIGNED <i>3/17/86</i>
22c. SIGNATURE <i>Harvey Kitzerow</i>		22d. DEGREE <i>MD</i>		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Harvey Kitzerow</i>		22g. ADDRESS <i>8926 Lebovitz Rd Clinton MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 20 March 86		23c. NAME OF CEMETERY OR CREMATORIAL Epiphany Church Cem		23d. LOCATION CITY OR TOWN Forestville		COUNTY		STATE Maryland	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Suitland		24b. ADDRESS Maryland		25a. DATE REC'D. BY REGISTRAR MAR 20 1986		25b. REGISTRAR'S SIGNATURE <i>Robert E. Wilhelm</i>					

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COLLECTOR

62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner or the pathologist of record must be notified of same.

00-01975

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 8 5

1. DECEASED NAME <b>ROSE FALCONE</b>				2a. DATE OF DEATH <b>03 29 86</b>	MONTH <b>03</b>	DAY <b>29</b>	YEAR <b>86</b>	2b. HOUR <b>10:50a<sub>m</sub></b>
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Jan 26 1912</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>	IF UNDER 1 YEAR <b>YRS</b>		IF UNDER 24 HRS <b>HOURS MIN.</b>	
7a. BIRTHPLACE <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY</b>				
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Walderf</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET ADDRESS / ZIP CODE <b>Box 185 - 11 Mill Hill Rd.</b>		20601	
14. FATHER'S NAME FIRST <b>Augusto</b>		MIDDLE <b>Celaicome</b>	LAST <b>Agastina</b>	FIRST <b>Robert P. Falcone</b>	MIDDLE <b>Coluzzi</b>	LAST <b>Walderf, Maryland</b>	ADDRESS <b>Box 185-11 Mill Hill Rd.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-84-0953</b>	17. INFORMANT <b>Robert P. Falcone</b>	APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH				
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):		<b>Pulmonary Hypertension</b>			1 hr			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <b>Pulmonary Hemorrhage</b>			2 mo.			
(c) <b>For Advanced Ca of Lung</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Diabetes c/o. P. P. Chronic Obstructive Pulmonary Disease</b>								
19. MEDICAL CERTIFICATION DATE OF OPERATION:		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>NO <input type="checkbox"/></b>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>NO <input type="checkbox"/></b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (s) this hospital attended to deceased from <b>3/16/86</b> to <b>3/29/86</b> , and that (s) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) did not view the body after death.								
22b. SIGNATURE <b>K. Minchin</b>		22c. DEGREE <b>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></b>	22d. ADDRESS <b>6188 OXON HILL RD BOX 6N HILL RD</b>	22e. DATE SIGNED <b>3/29/86</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/1/86</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Resurrection Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Clinton</b>	23e. COUNTY <b>P.G. Maryland</b>	23f. STATE		
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 01 1986</b>			25b. REGISTRAR'S SIGNATURE <b>Jane Davidson Pendee</b>			

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*W. olivaceus*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached from the form and sent to him. Then please remove carbon papers. Pages 1 and 2 should be sent to him and within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **DEATH**, any injury or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608 / 86	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Thelma	MIDDLE Doris	LAST Farnella	2a. DATE OF DEATH MONTH DAY YEAR JUNE 28, 1986			2b. HOUR 9P.M.		
1. SEX <b>Female</b>		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR JUNE 28, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b>					
10. CITY OR TOWN OF DEATH <b>RIVERDALE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LELAND MEMORIAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bank Supervisor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Citizens Bank</b>				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6013 43rd Avenue 20782</b>			
14. FATHER'S NAME FIRST <b>Benjamin</b>		MIDDLE <b>F.</b>	LAST <b>Huff</b>	15. MOTHER'S MAIDEN NAME <b>Mary E. Reidy</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-38-8886</b>		17. INFORMANT <b>Louis A. Farnella (Husband) Same as #13</b>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>COPD &amp; Asthmatic Bronchitis + Viral Syndrom</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (the hospital) attended the deceased from <b>1974-1-1</b> to <b>1974-6-19</b> , that (I) (we) last saw the deceased alive on <b>3-13-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <b>3/13/86</b>	
22b. SIGNATURE <b>S.C. Aryangat MD</b>		22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. ADDRESS <b>3308 Perry Street Mt. Rainier, Md. 20712</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/17/86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Brentwood P.G. Maryland</b>					
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b> 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jeanne Davidson Fender</b>							
										DHMH - 16 60M 7/B4 (VRA 15, 4)	

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00-02173

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8608/87

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
VIRGINIA M. FASTNAUGHT				3/26/86				11 a.m.			
3. SEX <input checked="" type="checkbox"/> Female		4. RACE Caucasian		5. DATE OF BIRTH November 19 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hillside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5012 Lee Jay Court 20743			
14. FATHER'S NAME FIRST George		MIDDLE Breedon		LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST Virginia Moreland		16. ADDRESS Same as 13 A-E			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Virginia Moreland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Pulmonary Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 887					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Pneumonia</i>		DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>C. Bronchi Syndrome, Rx Lt. Syring UTI</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/12</i> , 19 <i>86</i> , to <i>3/26</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>3/26</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. Johnson, M.D.</i>		22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3/26/86</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03/28/86		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood P.G.		COUNTY		STATE Maryland	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John Pendleton</i>							
DHMH - 16 60M 7/84 (VRA 15, 4) 6633 Old Alexander Ferry Rd, Clinton Md 20735 APR 02 1986											

0-68151

COLLECTIVE AGREEMENT

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 / 8 8				
										REG. NO.				
1 - FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Tomas Bernandino Feria										03	09	86	2:30 P.M.	
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. COUNTRY	IF UNDER 1 YEAR MONTHS DAYS			2d. HOUR
Male	White			MONTH 12 DAY 21 YEAR 24			61 YRS			U.S.A.				1430 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Peru	U.S.A.						PG							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale, Md	Leland Memorial Hospital										Cook	Hotel		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland	P.G.	Hyattsville				2504 Amherst Road	20783							
14. FATHER'S NAME	FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
Aurelio Feria				FIRST Evangelina										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No	579-88-3305			Maria Elbeheiry (Daughter) Same as #13										
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Septic ulcer														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost	(b) Name Sledaceq													
	(c) Septic splenic vein													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Coagulopathy														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
3-8-86 and 3-8-86	Perforated peptic ulcer			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN							
22a. I certify that (I) (this hospital) attended the deceased from March 8 - 1986, to March 9 - 1986, and that (I) (we) last saw the deceased alive on March 9 - 1986, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) did (did not) view the body after death.							COUNTY							
22b. SIGNATURE				DEGREE			STATE							
Gustavo Restrepo														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS													
Gustavo Restrepo	6215 Greenbelt Rd College Park Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN							
Cremation	3/12/86			Metropolitan Crematory			Alexandria N/A Virginia							
25a. FUNERAL DIRECTOR NAME	25b. ADDRESS			25c. DATE REC'D. BY REGISTRAR			25d. REGISTRAR'S SIGNATURE							
Francis Gasch's Sons Funeral Home, P.A.				MAR 14 1986			John Pendell							
4739 Baltimore Avenue Hyattsville, Md. 20781														

00-00356

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214 HOMOLOGUE

0-01451

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 - RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08189			
1- STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST Willard			MIDDLE Earl			LAST Finerson, Sr.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3/21 1986		2b. HOUR MONTH DAY YEAR 10:40 P.M.	
Male		Black		Jan. 27, 1921		65 yrs						2c. DATE PRONOUNCED DEAD 3/23 1986		2d. HOUR MONTH DAY YEAR P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
Missouri		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1427 Capitol View Terrace										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Soldier		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army 20785	
Landover															
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1427 Capitol View Terrace							
14. FATHER'S NAME Sam		15. MOTHER'S MAIDEN NAME Finerson													
Carrie		Prince													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1943-1946		17. INFORMANT Willard E. Finerson, Jr.		ADDRESS 361 Jefferson Ave. Brooklyn, N.Y.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None															
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER 1919 Seminary Road										DATE SIGNED 3/24/86			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery County, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-28-86		23c. NAME OF CEMETERY OR CREMATORIAL HARMONY CEMETERY		23d. LOCATION CITY OR TOWN LANDOVER, PR. GEO. MARYLAND									
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. ADDRESS 4339 HUNT PLACE, N.E.						25a. DATE REC'D. BY REGISTRAR MAR 26 1986		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>							
WASHINGTON, D.C. 20019															

12110-0

re: [redacted]

[redacted]

[redacted]



YORK COUNTY, PENNSYLVANIA  
POST OFFICE DEPARTMENT  
TEN DOLLARS  
RECEIVED  
1902-03-10

00-02025

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES.

AFTER DEATH, WHETHER THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08790	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
Elsie M. Fleet						3-22-1986							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
Female	Black	6 25 '15	70 yrs.	MONTHS DAYS	HOURS MIN	3-22-1986							
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	USA					Prince George's							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IN WHICH DECEASED WAS RECEIVED)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY	
Clinton	Southern Maryland Hospital												
13. STATE	13a. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			13f. ADDRESS				
Maryland	Prince Geo	Brandywine	Rt. 3 Box 540 Martin Rd.						14303 Neal Drive				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS			Brandywine, Md. 20613			
William	O.		Brooks	Janie L.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF 888 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No	518-22-6010	Lora Harper			Diabetic arteriosclerosis cerebral vascular disease								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF 888 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.	(b) DUE TO, OR AS A CONSEQUENCE OF			(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  Right hip fracture.													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3/19/86	Right hip fracture												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21e. LOCATION STREET CITY OR TOWN COUNTY STATE		
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	11:54 A.M. 3-15-1986	Fall by herself			Harris Home			9211 Stuart Lane, Clifton, Md. 20735					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE: <i>Aurora J. Longway Deputy M.D.</i> MEDICAL EXAMINER												DATE SIGNED: 3-23-86	
EXAMINER'S NAME (TYPE OR PRINT): <i>Aurora J. Longway</i>												ADDRESS: 5019 Raymont St., Clifton Springs, NY	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial			23b. DATE: 27 Mar '86	23c. NAME OF CEMETERY OR CREMATORIAL: Asbury VMC			23d. LOCATION CITY OR TOWN: Brandywine P.C.			23e. STATE: Md.			
24. FUNERAL DIRECTOR NAME: Martell Adams			ADDRESS: Aquasco Md.										
25a. DATE REC'D. BY REGISTRAR: APR 01 1986												25b. REGISTRAR'S SIGNATURE: <i>BP</i>	
DHMH - 17 (VR A15 ME (5))												15M 2/80	

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1 -  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 8 / 9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part II may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Yes", show any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
ANNA					flowers	3	8	86	12:28 A.M.		
3. SEX		4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		Black	MONTH	DAY	YEAR	91	YRS.	IF UNDER 24 MRS.			
7a BIRTHPLACE (STATE OR FOREIGN)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTHS		DAYS	
N.C.		U.S.A.									
10 11 12 13 14 15 16 17 18 19 20 21 22 23 24		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Chesapeake		Prince Georges Hospital			Housewife			5702 Landover Rd. 20785			
13a STATE Md.		13b COUNTY Prince Geo.	13c CITY OR TOWN Chesapeake	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
PRESTON			Jen Kins	DORA				Pits			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b SOCIAL SECURITY NO. UNK			17. INFORMANT			ADDRESS			
NO								MARY Hied, Rt 1 Box 15, Dodge City, N.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS											
DUE TO, OR AS A CONSEQUENCE OF (b) ABDOMINAL ABSCESS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) CHOLEDOCHOCUTANEOUS FISTULA											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BILATERAL CRYPTOSIS; CAROTENOID ANEMIA; CONGESTIVE HEART FAILURE											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
19b					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21b											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
21d											
22a I certify that (I) (this hospital) attended the deceased from <u>3/17/86</u> to <u>3/8/86</u> , and that (my) opinion death occurred on the date and hour and from the causes stated saw the deceased on <u>3/17/86</u> abn. did not know the body after death.											
22b SIGNATURE											
22c DATE SIGNED <u>3/8/86</u>											
22d. PHYSICIAN'S NAME (IN BLOCK LETTERS)		22e DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f ADDRESS 7500 Greenway Dr DR GREENBELT MD 20770			
23a BURIAL, CREMATION, REMOVAL (CITY)		23b DATE 3-14-86			23c NAME OF CEMETERY OR CREMATORIAL PRESSURE			23d LOCATION CITY OR TOWN			
Burial		3-14-86			HARRISON FAMILY CEMT. Edgecomb Co. Piney N.C.						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
VANN AND Williams 4804 Ga Ave N.W. DC								MAR 13 1986			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 08 / 92

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME <b>Dorothy W. Ford.</b>			2a. DATE OF DEATH <b>March 4, 1986</b>	2b. HOUR <b>1:55 p.m.</b>		
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>MONTH: SEPT. DAY: 8, YEAR: 1901</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84 yrs.</b>	7. IF UNDER 1 YEAR <b>MONTHS: 0 DAYS: 0</b>	8. IF UNDER 24 HRS. <b>HOURS: 0 MIN: 0</b>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA</b>	9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	9c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES MD.</b>			
10. CITY OR TOWN OF DEATH <b>ADELPHI</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRESIDENTIAL Woods Nursing Home</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUSINESS</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>
13a. STATE <b>M.D.</b>	13b. COUNTY <b>PR. GEO</b>	13c. CITY OR TOWN <b>Takoma Park</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET ADDRESS / ZIP CODE <b>900 DAVIS AVENUE 20912</b>		
14. FATHER'S NAME FIRST <b>WILLIAM</b>	MIDDLE <b></b>	LAST <b>HAMPSHIRE</b>	15. MOTHER'S MAIDEN NAME FIRST <b>MARIE</b>	MIDDLE <b></b>	LAST <b>HAMPSHIRE</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>579-44-3679A</b>	17. INFORMANT <b>MARION P. FORD</b>	ADDRESS <b>1921 Kalorama Rd. N.W. DC</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>			
Advanced Parkinsonism						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
(b)						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
<b>generalized arteriosclerosis, chronic anemia</b>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				<b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	<b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-20-86</b> to <b>3-4-86</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>2-20-86</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.						
22b. SIGNATURE 	22c. DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <b>3-4-86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George F. Snostack, M.D.</b>	22e. ADDRESS <b>9241 Columbia Blvd. Silver Spring, Md. 20910</b>					
23b. BURIAL, CREMATION, REMOVAL METHOD <b>Burial</b>	23c. DATE <b>March 7, 1986</b>	23d. NAME OF CEMETERY OR CREMATORIAL <b>Presbyterian Cemetery Adelphi</b>	23e. LOCATION CITY <b>Adelphi</b> COUNTY <b>Maryland</b> STATE <b>M.D.</b>			
24. FUNERAL DIRECTOR NAME <b>Kultur Kellers</b>	25. DATE RECEIVED BY REGISTRAR/25. REGISTRAR'S SIGNATURE <b>Takoma Funeral Home Inc. 254 Carroll St. N. W. D. MAR 7 1986</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 states any injury, or other traumatic event, the medical examiner must be notified.



066224

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 / 9 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
			John	M	Ford	March 2, 1986				12:40pm			
3. SEX		4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Black	November 20, 1914			71	YRS	MONTHS	DAYS	HOURS	MIN.		
7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Virginia		United States			Prince George's MD.								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Riverdale		Leland Memorial			Retired-Bank Worker		Bank						
13a. STATE MD.						13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4923 56th Avenue	
14. FATHER'S NAME FIRST Unknown						15. MOTHER'S MAIDEN NAME FIRST Atha Fauntroy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT		ADDRESS							
		225-10-1198		Wendy Hopkins Daughter Same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) _____ Hypertension with Dehydration							
						DUE TO, OR AS A CONSEQUENCE OF (c) _____ Acute in Chronic Renal Failure							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Hypertensive Cardiovascular Disease; Anaemia; Aspiration Pneumonia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-1-86, 1986, to 3-2-, 1986, that (I) (we) last saw the deceased alive on 3-2-, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Atha Fauntroy</i>		22c. DEGREE M.D.		22d. ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 3-2-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ghulam M. Din, M.D.		22e. ADDRESS 6510 Kenilworth Ave., Riverdale, Md. 20737											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06 March 86		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home		ADDRESS 389 R.I. Ave. N.W.		25a. DATE REC'D. BY REGISTRAR MAR 5 1986		25b. REGISTRAR'S SIGNATURE <i>Jean Davidson-Randall</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of Form 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If the medical examiner has not certified death, the medical examiner must be consulted before the certificate is signed.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the physician certifying death must consult with the medical examiner.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

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OXFORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit. Then please remove carbon copies prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 38 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 0 8 / 9 4
											REG. NO.	
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR	
	John Edward FRANK						3	3	18-86	12-22	M	
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
M	Caucasian			Jan. 20, 1913			73			IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE COUNTRY Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Fireman			12b. KIND OF BUSINESS OR INDUSTRY D.C. Fire Dept.			
13a. STATE Maryland			13b. COUNTY Pr. George Riverdale			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5600 54th Avenue 20737			
14. FATHER'S NAME FIRST James			MIDDLE M.			15. MOTHER'S MAIDEN NAME FIRST Sarah			LAST Poore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-44-1735			17. INFORMANT Agnes McKesson-2228 N. Buchanan St. Arl, Va.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETIS MELLITUS												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a HYPERTENSIVE CARDIOVASCULAR DUE APE												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-18-1986 to 3-18-1986, that (I) (we) last saw the deceased alive on 3-18-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. SIGNATURE K. J. Matthew			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. J. MATTHEW			22e. ADDRESS 6570 KENILWORTH AVE RIVERDALE MD 20737									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE March 21, 86			23c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens Cem.			23d. LOCATION CITY OR TOWN Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Arlington Funeral Home 3901 N. Fairfax Dr. Arlington, Virginia						25a. DATE REC'D. BY REGISTRAR MAR 24 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton			

57810-00

COLLECTOR

00-0003

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 / 9 5

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND SEND THE MEDICAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3 RETAIN COPIES FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST JAMES	MIDDLE W.	LAST FRYE	7a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED Mar 07 1986	MONTH M	DAY 07	YEAR 1986	2b HOUR M	
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH Feb.	DAY 11	YEAR 1986	6 AGE (IN YEARS LAST BIRTHDAY) YRS. 24	IF UNDER 1 YR. MONTHS 24	IF UNDER 24 HRS. HOURS 0	MIN. 0	2d HOUR 10:10 p.m.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A			12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a STATE Maryland	13b COUNTY Charles	13c CITY OR TOWN Waldorf			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 202 Hatteras Cir. 20601				
FATHER'S NAME FIRST William		MIDDLE E.	LAST Frye III			15 MOTHER'S MAIDEN NAME FIRST Cynthia	MIDDLE J.	LAST Rector		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) N/A		16b SOCIAL SECURITY NO. N/A			17. INFORMANT William E. Frye III Same as 13 A-E			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complex congenital heart defects DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION 2-13-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Congenital defects			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Natural causes					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 3/7/1986		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 03-11-86		23c NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d LOCATION CITY OR TOWN Suitland		COUNTY P. G.	STATE Maryland
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		ADDRESS 6633 Old Alexander Ferry Road Clinton, Md. 20735			25a DATE REC'D. BY REGISTRAR MAR 12 1986			25b REGISTRAR'S SIGNATURE		
VR A15 ME (5)										

18000-00



10-00959

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 6 0 8 / 9 6

1 - STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIR

MIDDLE

LAST

Rupert · Frank

Frye

20. DATE KNOWN  
OF ESTI-  
DEATH MATED

MONTH DAY YEAR

2b. HOUR

MONTH DAY YEAR

2b. HOUR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH ITEM 1, FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. BAGS 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR

Aug 2 1904

6. AGE (IN YEARS  
LAST BIRTHDAY)

YRS.

81

7. IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.  
HOURS MIN24. DATE  
PRONOUNCED

MONTH DAY YEAR

3-15 86

8. DATE  
ESTI-  
DEATH MATED

MONTH DAY YEAR

3-15 86

M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED  NEVER MARRIEDWIDOWED DIVORCED 

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

10. CITY OR TOWN OF DEATH

Suitland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Andrews APB Med. Cncl

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Ret Oper Eng

12b. KIND OF BUSINESS  
OR INDUSTRY

DC Gov't

13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

Pr Geo

13c. CITY OR TOWN

Ft Washington

13d. INSIDE CITY LIMITS?  
YES  NO 

13e. STREET ADDRESS

6800 Janet Lane

20744

14. FATHER'S NAME

Cornelius Martin

FIRST MIDDLE LAST

Frye

15. MOTHER'S MAIDEN NAME

Idella

MIDDLE

Reed

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

Yes

WWII

16b. SOCIAL SECURITY NO.

577 44 1474

17. INFORMANT

Edna Marie Frye

ADDRESS

Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

{ (b)

DUE TO, OR AS A CONSEQUENCE OF

{ (c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES  NO 21a. EXTERNAL CAUSE WAS  
UNDERLYING  OR  
CONTRIBUTING  CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21 PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE  NOT WHILE   
AT WORK  AT WORK 21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner Autopsy  Inspection  Inquiry  and in my opinionACTUAL  
SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE  
SIGNED

3-16-86

EXAMINER'S NAME  
(TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION

CITY OR TOWN

COUNTY Maryland STATE

Burial

18Mar1986

Trinity Mem Gardens

Waldorf

Robert E. Wilhelm Funeral Home

Suitland Maryland

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAR 20 1986

Julia Swisher Rodriguez

63290-8

041088AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be retained 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "No" to any injury or other traumatic event, the medical examiner must be notified.

CLEARED BY DR. RODRIGUEZ, D.M.B.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 / 9 1					
										REG. NO.					
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			FRANK			JAMES GAMMINO			March 8, 1986					7:26a M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Caucasian			June 22, 1932			53 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania			USA								Prince George's County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Lanham			AMI/Doctors' Hosp. of Pr. Geo. Co.			Pharmacist			Pharmaceutical						
SPECIAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?					
14. STATE			15. COUNTY			16. CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland			Pr George's			Mitchellville					12000 Lisborough Road 20716				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO			195-24-8757			Adriane G. McGinn			111 Deep Dale Drive Timonium, MD 21093						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coarcto - Intestinal bleeding</i> (c) <i>Chronic Renal Failure</i> (d) <i>Malignant Hypertension</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 19 <u>86</u> , to <u>March 8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/9/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED					
22b. SIGNATURE <i>Moshyedi</i>			22d. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			<u>3-9-86</u>						
22e. ADDRESS Dr. Ata O. Moshyedi, M. D.										22e. ADDRESS 5632 Annapolis Road Bladensburg, MD 20710					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE MAR 10, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, Pr. George's, MD		CITY OR TOWN COUNTY STATE				
Burial															
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043			25a. DATE REC'D. BY REGISTRAR MAR 12 1986			25b. REGISTRAR'S SIGNATURE						

01399-00



ИСТОРИЧЕСКИЙ МАТЕРИАЛ



ОБРАЗОВАНИЕ И КУЛЬТУРА В СОВРЕМЕННОМ РОССИИ

Сборник научных статей и рецензий

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Box 1, line 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 show an injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8608/98						
												REG. NO. 1						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
MACK			E	GATTIS		MAR			4	86	1515	M						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.						
Male		White		MONTH DAY YEAR March 10 1918			67 YRS.			MONTHS DAYS		HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Georgia		United States					Prince George's											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
AAFB		Malcolm Grow Medical Center		retired M/Sgt			USAF											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE								
Maryland		Pr George		Forestville			YES <input type="checkbox"/> NO <input type="checkbox"/>			2565 Oak Glen Way			20747					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST								
Mack		Donald	Gattis		Elsie					Yarbrough								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR & DATES)		17. INFORMANT			ADDRESS											
Yes		1941-1965		255 12 4921 Sibyl A Gattis			Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for each section) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												CARDIOPULMONARY ARREST <i>Cardio pulmonary arrest</i>						
DUE TO, OR AS A CONSEQUENCE OF (b)												CONGESTIVE HEART FAILURE AND DYSRHYTHMIA <i>Congestive heart failure and dysrhythmia</i>						
(c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 18 FEBRUARY 86 to 4 March 19 86, that (I) (we) last saw the deceased alive on 4 March 19 86 and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Timothy Ladner</i>												DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4 March 86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			MALCOLM GROW USAF MEDICAL CENTER AAFB MD												
TIMOTHY LADNER																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE					
Burial			7 March 1986			Arlington National			Arlington			Arl	VA					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Robert E. Wilhelm Funeral Home			Suitland, MD			MAR 17 1986			Gloria Davidson-Ramsey									

1370



**TO HOSPITAL OR ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician

~~TO FUNERAL DIRECTOR~~ After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove pages 1 and 2 and file within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

**IMPORTANT:** If Item 21 is marked or **Item 18 shows** with the State Dept. of Health and Mental Hygiene

MEDICAL CERTIFICATION

~~1 - STATE  
REGISTRATION~~

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

6 . 0 8 / 9 9  
REG. NO. 1

REG. NO.

DECEASED NAME <b>HENRY</b>			FIRST <b>D.</b>	MIDDLE <b></b>	LAST <b>GEORGE</b>	2a DATE OF DEATH <b>03 23 86</b>	MONTH <b>03</b>	DAY <b>23</b>	YEAR <b>86</b>	2b HOUR <b>4 30PM M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>October</b>	DAY <b>5,</b>	YEAR <b>1918</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>	IF UNDER 1 YEAR MONTHS <b>YRS</b>	IF UNDER 24 HRS HOURS <b></b>	MIN. <b></b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>							
10 CITY OR TOWN OF DEATH <b>CHEVERLY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plant Manager</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Coca Cola Co.</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3400 63rd. Place 20785</b>				
14 FATHER'S NAME FIRST <b>William</b>	MIDDLE <b>Cross</b>	LAST <b>George</b>	15 MOTHER'S MAIDEN NAME FIRST <b>Ruby</b>		MIDDLE <b></b>	LAST <b>Padgett</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>238-14-9805</b>		17 INFORMANT <b>Mr. Ronald D. George Arnold, Md. 21012</b>		ADDRESS <b>427 Glen View Ct.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cancer in Nut</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Varicose Hemorrhoid</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Congestive heart failure</i>										
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET	CITY OR TOWN		COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>19 17 10 303</b> , that (I) (we) last saw the deceased alive on <b>19 17</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) view the body after death.										
22b. SIGNATURE <i>S. JUNTA</i>			DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d PHYSICIAN'S NAME <i>S. JUNTA</i>			22e. ADDRESS <i>PG HOSPITAL</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>March 26, 1986</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Brentwood</b>	23e. COUNTY <b>P.G.</b>	23f. STATE <b>Maryland</b>	24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>				
25a. DATE REC'D. BY REGISTRAR <b>MAAR 26 1986</b>					25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendleton</i>					

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benefits, reflecting a more positive view.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08800						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
<i>Helen</i>			<i>L.</i>			<i>Gibson</i>						<input type="checkbox"/>	3-30	1986	M	9:23		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Female		White		June 20 1935			50							3-30	1986	A	9:23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH									
Wash D.C.			USA			<input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			Prince George									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Clinton			Southern Maryland Hospital Center									Housewife			at home			
13a. STATE Maryland			13b. COUNTY Pr. George			13c. CITY OR TOWN Temple Hills			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7305 Loch Raven Rd. 20748							
14. FATHER'S NAME Cecil			MIDDLE J.			LAST Six			15. MOTHER'S MAIDEN NAME First Catherine		Middle E.		Last Fisher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
no			579-48-0911			Ronald J. Gibson same as item 13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive cardiovascular disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																		
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																		
(c) _____																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												and in my opinion						
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER									DATE SIGNED 3-30-86						
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 5009 Rayburn Ct, Temple Hills, Md.															
23a. BURIAL, CREMATION, REMOVAL			23b. DATE 4/3/86			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veteran Cemetery Cheltenham			23d. LOCATION CITY OR TOWN		23e. COUNTY	STATE						
24. FUNERAL DIRECTOR NAME G.P. Kalas			ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.			25a. DATE REC'D. BY REGISTRAR APR 03 1986			25b. REGISTRAR'S SIGNATURE <i>Jeanne Dawson Pendell</i>									
DVHMH - 17 (VR A15 ME (5))																		

03 2001 03 075

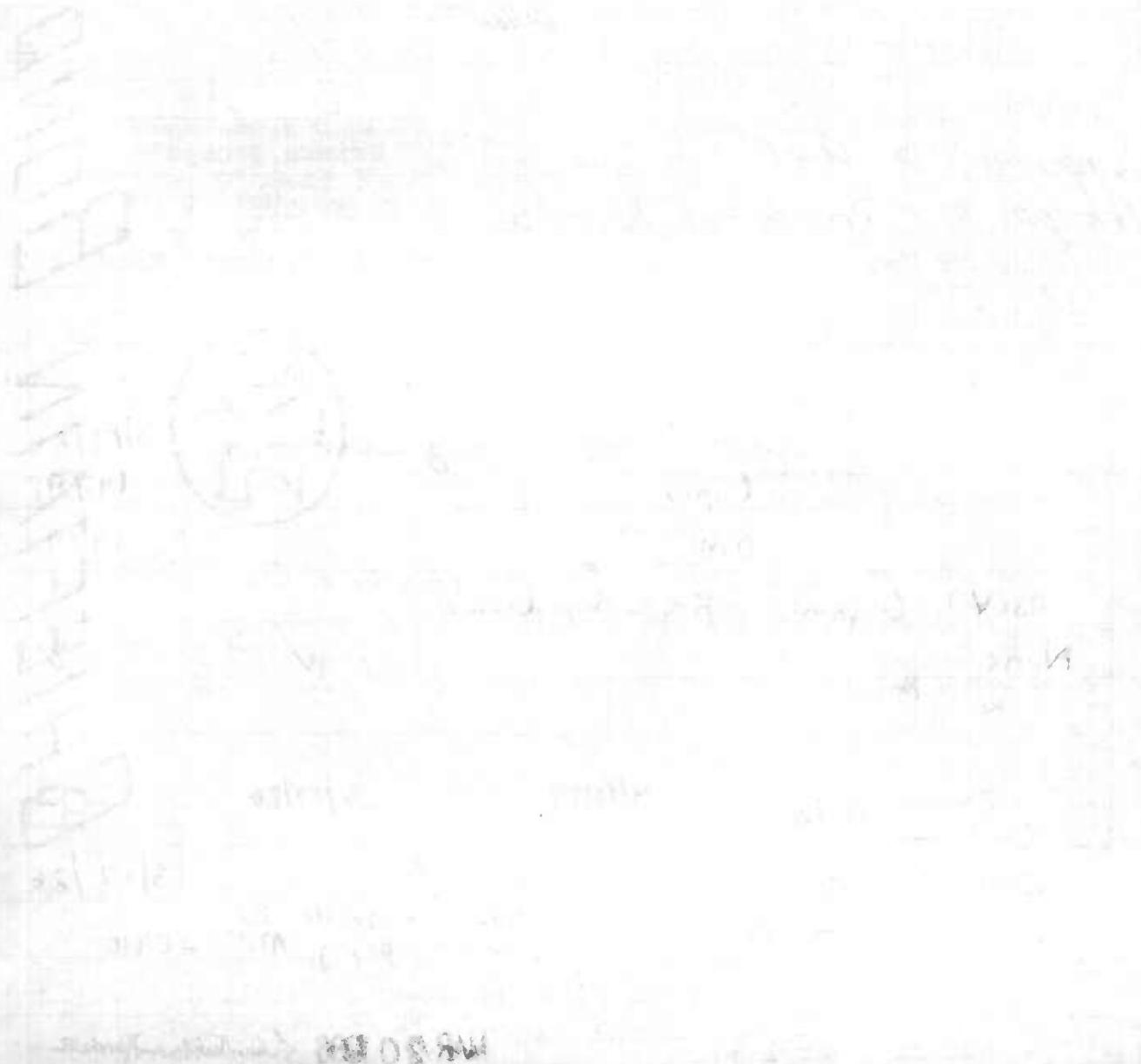
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or checked, I certify that (1) this hospital attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, that (2) I last saw the deceased alive on \_\_\_\_\_, and that in my opinion death occurred on the date and hour and from the causes stated above. (1) and (2) did not view the body after death.)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608801	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE		1. LAST Gillen		2. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 6:50 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 17 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS 25		8. IF UNDER 24 HRS HOURS 6 MIN. 50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cumberland MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Baltimore MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Adelphia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1801 Metzerott Road 20783			
14. FATHER'S NAME Archibald B. Lovenstein				15. MOTHER'S MAIDEN NAME Blanche		16. ADDRESS So. Temple Hills Md		17. MIDDLE Benson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 568 05 2046A		17. INFORMANT Dorothea F. Duckwell 3312 B-1 Huntley							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Cardiopulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/17/86	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).		DUE TO, OR AS A CONSEQUENCE OF COPD								1979	
		DUE TO, OR AS A CONSEQUENCE OF DM								1979	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ASCVD, Organic Brain Syndrome											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from 4/18/79 to 3/17/86, that (2) I last saw the deceased alive on 3/13/86, and that in my opinion death occurred on the date and hour and from the causes stated above. (1) and (2) did not view the body after death.											
22b. SIGNATURE MB Patrick III MD		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/17/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GB Patrick III MD		22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910									
23a. BURIAL, CREMATION, REMOVAL (TYPE) Cremation		23b. DATE 18 March 86		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION Suitland		COUNTY		STATE	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home NAME Suitland Maryland				25a. DATE REC'D. BY REGISTRAR MAR 20 1986		25b. REGISTRAR'S SIGNATURE Julie Davidson-Pendell					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 8 0 2

REG. NO.

1 - STATE  
REGISTRAR

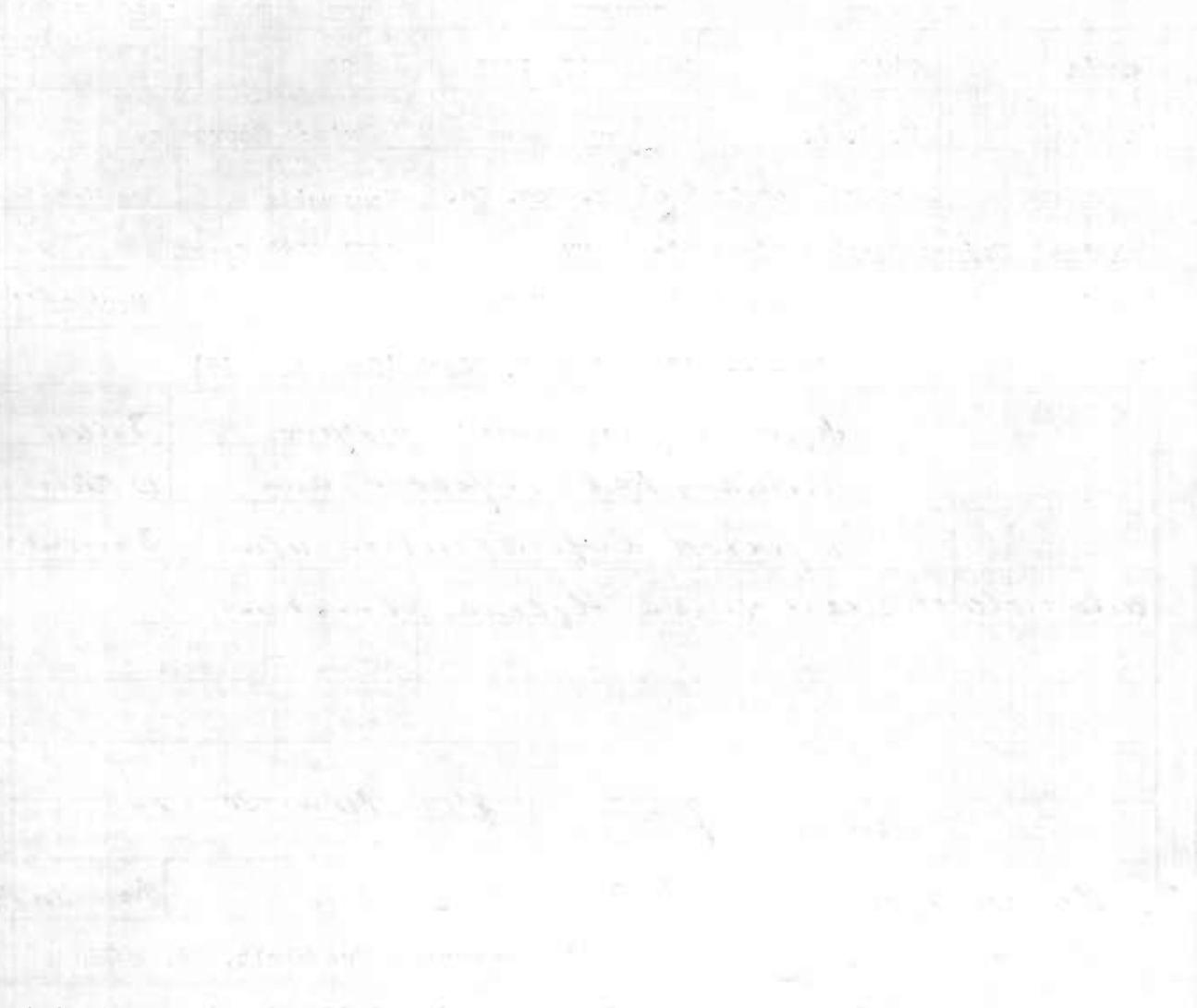
I. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
FLORENCE GODLEY							MARCH	30	1986	9:30A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
Female		White		August 17, 1893		92		YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Lanham		Doctors' Hospital of Pr. Geo. Co.				Housewife			Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6371 67th Court 20840				
Maryland		Prince Georges		Riverdale								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
Morris				Bernstock	Kate				Mowrgraff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
NO		220-50-6519		Joan G. Block (Same as # 13)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
3 days												
18. CAUSE OF DEATH (Enter only one cause per line for part (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Septic &amp; pneumonia or septic</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>Coronary tract infection and</u>												
(b) <u>Infected large decubitus ulcer</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>infected large decubitus ulcer</u>												
(c) <u>3 months</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<u>astenoclerotic heart disease Alzheimer disease</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 24, 1986</u> to <u>Aug 24, 1986</u> , that (I) (we) last saw the deceased alive on <u>Aug 30, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>J. Bergemann</u>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22f. DATE SIGNED <u>Aug 31, 1986</u>						
Till Bergemann, M.D.		115 Centerway, Greenbelt, Md. 20770										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY/TOWN		23e. STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
Burial		4/1/1986		King David Mem. Garden		Falls Church, Virginia						
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <u>John D. Wilson</u>						
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.		APR 3 1986										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon paper. Page 1 and 2 should be filled in with ink. Please attach this certificate to the burial permit. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked **NO**, show any injury, ailment, trauma or event that the medical examiner must be informed about.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript permit. Then please remove either pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85108803		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ELBERT					GOODMAN	MAR 25 86					1100 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		# UNDER 24 HRS.		
Male		Black		MONTH DAY YEAR June 12, 1930		55		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		United States				Prince Georges		MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Forestville		Malcolm Grow A.F. Hospital		Military Airman		U.S. Air Force		20745				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7526 Abbington Drive				
14. FATHER'S NAME FIRST Jessie		MIDDLE	LAST Goodman	15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE	LAST Bond					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. Retired		17. INFORMANT		ADDRESS Oxon Hill Md						
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) RESPIRATORY FAILURE												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 MARCH 1986 to MARCH 25, 1986, that (I) (we) last saw the deceased alive on MARCH 25 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Horace Tsu</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 25 MARCH '86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Horace Tsu		22f. ADDRESS MGMC - SGE										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/86		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION CITY OR TOWN Arlington,		COUNTY	STATE Virginia			
24. FUNERAL DIRECTOR ALEXANDER S. POPE-2617 Pa Ave SE Wash., D.C.		25a. DATE 3/31/86		25b. REGISTRAR'S SIGNATURE <i>Alexander Pope</i>								
BP _____												
DHMH - 16 60M 7/84 (VRA 15, 4)												

O-03390



00-02686 FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 8 6 0 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
ALYCE W. GOSNELL				03 30 86				11:45AM
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 14, 1898</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Seabrook</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>9317 Woodberry St. 20706</b>				
14. FATHER'S NAME FIRST <i>UnKnown</i>	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>UnKnown</i>	MIDDLE	LAST	ADDRESS <b>Maryland Woodberry St, Seabrook,</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>266-48-4367</b>	17. INFORMANT <b>Joan North 9317</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Serous electrolyte imbalance</b>								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Dehydration, claim and infection.</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>2</b> , 19 <b>85</b> , to <b>3/30/86</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/30/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If in doubt, did not see the body after death.)								
22b. SIGNATURE <i>A. Clark Holmes, M.D.</i> DEGREE								
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>3/30/86</b>						
22e. ADDRESS <b>14314 OLD MARLBORO PIKE UPP. MARLBORO, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4-1-86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lee Crematory</b>		23d. LOCATION CITY STATE TOWN COUNTY STATE <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>Rendon/Hale Lanham F.H.</b> 9013 Annapolis Rd., Lanham, MD. 20706		25a. DATE REC'D. BY REGISTRAR <b>APR 07 1986</b> 25b. REGISTRAR'S SIGNATURE <i>John A. Holmes</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified to by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1, 2, and 3 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with an "X" show any injury, or other traumatic event, the medical examiner shall be notified.



no. 62. This book is loaned to you by the  
University of Southern California Library

and is to be returned to the library

within 30 days.

X

not loaned or renewed until the following  
month unless otherwise arranged.  
1917. It is expected to be returned

00-01028

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 8 0 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST CLARENCE	MIDDLE I.	LAST GRAY	2d. DATE OF DEATH 03-12-86	MONTH DAY YEAR	2b. HOUR 10.10PM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1906			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming				
13a. STATE Md.		13b. COUNTY P.G. Seat Pleasant		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 707 65th Ave. 20743			
14. FATHER'S NAME FIRST Isaiah		MIDDLE	LAST Gray	15. MOTHER'S MAIDEN NAME Frances			16. ADDRESS P.O. Box 242 Brandywine, Md.		17. INFORMANT Rose H. Gray-		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-20-2606		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction and DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive heart disease 7 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. CHRONIC RENAL FAILURE; OBSTRUCTIVE LUNG DISEASE; Hypoglycemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED At Home <input type="checkbox"/> Work <input type="checkbox"/> Job <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I, the physician) attended the deceased from the time he/she decreased alive on or about 3/12/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated and that in (my) (our) opinion death occurred on the date and hour and from the causes stated I did not view the body after death		22b. DATE 3/12/86		22c. DEGREE		22d. DATE SIGNED 3/12/86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Sussler M		22f. ADDRESS 7500 Greenway Ln Dr		22g. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22h. DATE REC'D. BY REGISTRAR MAR 20 1986					
23a. FUNERAL DIRECTOR NAME A. S. WASHINGTON & SONS ADDRESS 4925 BURLAUGHS AVE. W.		23b. DATE 3-18-86		23c. NAME OF CEMETERY OR CREMATORIAL HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN Lanover, P.G., MD.					
24. FUNERAL DIRECTOR NAME A. S. WASHINGTON & SONS ADDRESS 4925 BURLAUGHS AVE. W.		25a. DATE REC'D. BY REGISTRAR MAR 20 1986		25b. REGISTRAR'S SIGNATURE John J. Kildare, Jr.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be  
retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35011-00



00-00877

1-  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

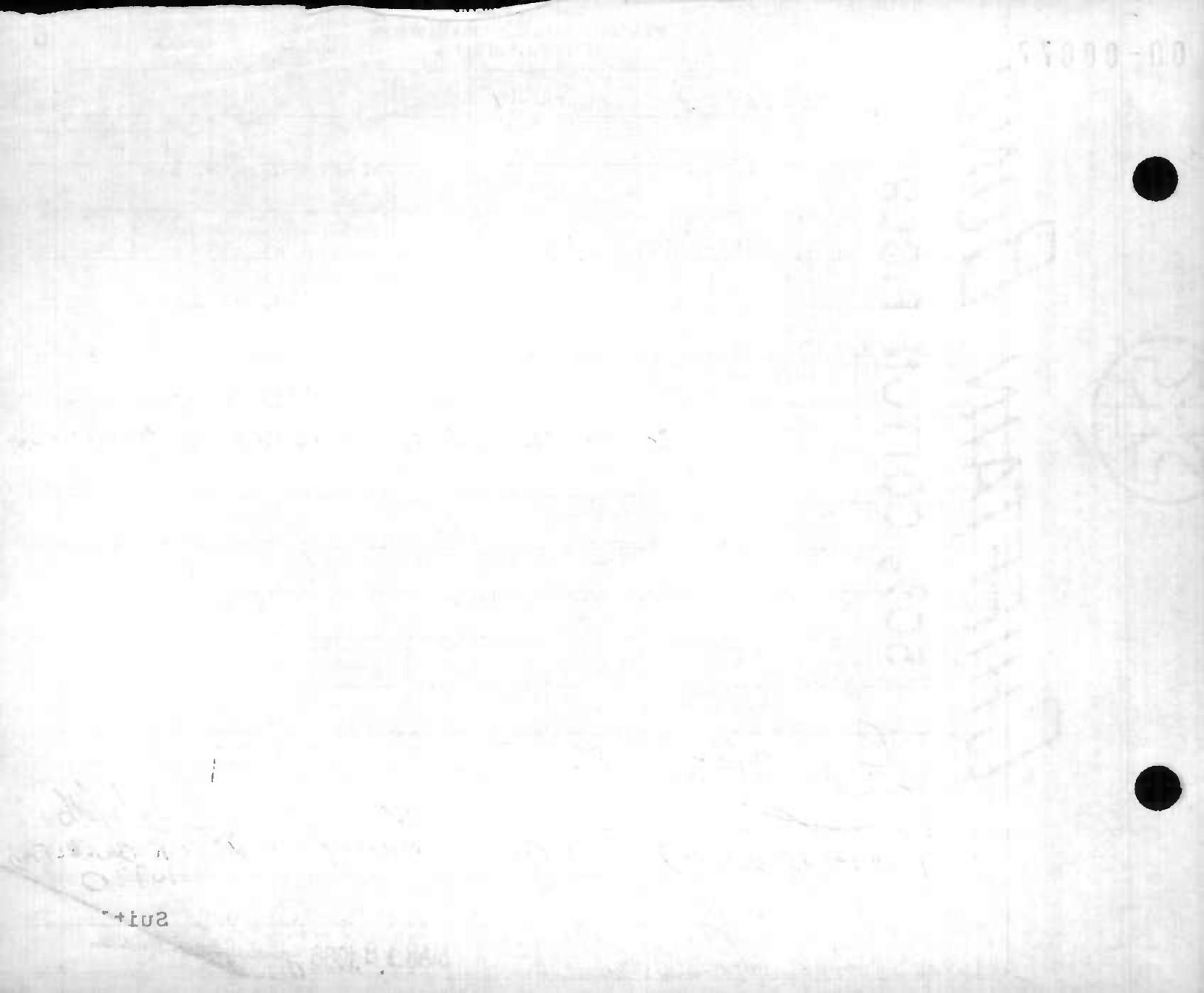
8 0 0 8 3 0 6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. If completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon from pages 1 and 2 (should be filed within 72 hours after death)

IMPORTANT: If item 21 is marked as "No" (16 thru 20 any injury, or other traumatic event, the medical examiner must be notified at once)

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>ESTELLE J. GRAY</i>						3-5-86				3:15 p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		Black		MONTH	DAY	YEAR	78	78	YRS	IF UNDER 24 HRS		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Alabama		USA		<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input checked="" type="checkbox"/> DIVORCED	PG				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Adelphi, Maryland		Presidential Woods 1801 Metzerott Road			Retired -Nurse			20783				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Maryland		PG		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		825 Chillum Road				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Sandy Johnson					Etta Hicks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
no		577 16 4856		Gloria Banks-daughter-319 Quackenbos								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE CARDIOMYOPATHY</i>											ST. MONTHS → YEARS	
Conditions, if any, which gave rise to immediate cause (a), stating if the underlying cause lost (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED (IF YES, INDICATE MEDICAL EXAMINER) AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT PLAY <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (he/his hospital) attended the deceased from now until his/her death on <i>2/20/86</i> to <i>2/21/86</i> , and that (1) (we) last viewed the deceased either on <i>2/20/86</i> or <i>2/21/86</i> and that (1) (we) last viewed the body after death.		22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. Schlesser MD</i>		22f. ADDRESS <i>7500 Greenway Ln. Ste. 20720</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY			STATE
Burial		March 10, 1986		Lincoln Memorial Cemetery			Suitland, Md.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
John T. Stewart		MAR 18 1986		John Davidson								
Stewart Funeral Home-4001 Bonn. Rd. N.E.												

00-00043



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.  
**TO FUNERAL DIRECTOR:** PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5A. RETAIN PAGE 5 FOR YOUR FILES.  
**AFTER DEATH:** WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00-01779

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08301						
1- STATE REGISTRAR												2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR		
James Gustavus Gray, 3rd			<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			3	26	1986	M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR MONTH DAY YEAR				
male		caucasian		4 13 1933		53						3 26 1986		12:42 p.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA													Prince George's County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY				
Laurel			Rt. 197 & Muirkirk Road									Warehouseman		GiantFood				
13a. STATE Md.			13b. COUNTY Prince George		13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9506 Muirkirk Rd.		20708						
14. FATHER'S NAME FIRST James MIDDLE G. LAST Gray, Jr.			15. MOTHER'S MAIDEN NAME Elizabeth									16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			16b. SOCIAL SECURITY NO. 577-46-8423									17. INFORMANT Loretta Gray same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 12:30a. 3 26 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/van impact												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET Rt. 197 & Muirkirk, Laurel, P.G. CO, MD.												
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																
EXAMINER'S NAME (TYPE OR PRINT)		MARGARITA A. KORELL, M.D.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		3/29/86		Ivy Hill Cemetery			Laurel		P.G.		Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		7001 Sandy SPR. Rd.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
FLECK F.H. INC.		LAUREL, MD. 20707		MAR 31 1986			John Anderson											
DHMH - 17 (VR A15 ME (5))																		

251-00

Oliver H. Johnson  
1900-1902

FRANKLIN  
GREEN  
071119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608308		
1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
FRANKLIN C.					GREEN, Sr.	MARCH	4, 1986			2:07 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
MALE		CAUC.		MONTH JAN	DAY 25	YEAR 1910	76		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Washington, D. C.		U.S.A.				PRINCE GEORGE						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Laurel		Greater Laurel-Beltsville Hosp.		Internal Revenue Service		20902						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		1111 University Blvd. W. # 218		
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		ADDRESS		LAST		
14. FATHER'S NAME		FIRST Harry	MIDDLE C.	LAST Green	15. MOTHER'S MAIDEN NAME		Adelaide		Perkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		578-38-9722		Claire Green Wife Same as 13								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia, sepsis, resp distress synd.</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Post CVA.</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>11/23</i> , 19 <i>86</i> , to <i>Present</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/14</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Luis A. Casas</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/4/86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Luis A. CASAS</i>		22e. ADDRESS <i>14201 Laurel Rd Dr #221 Laurel Md 20707</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Mar. 6, 1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Suitland</i> COUNTY <i>Pr. Geo. Maryland</i> STATE						
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins Jr.</i> <i>500 University Blvd. W. Silver Spring, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 10 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Pandell</i>				

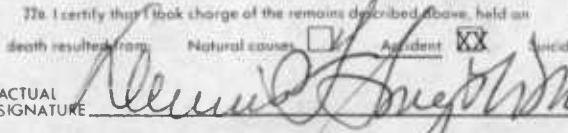


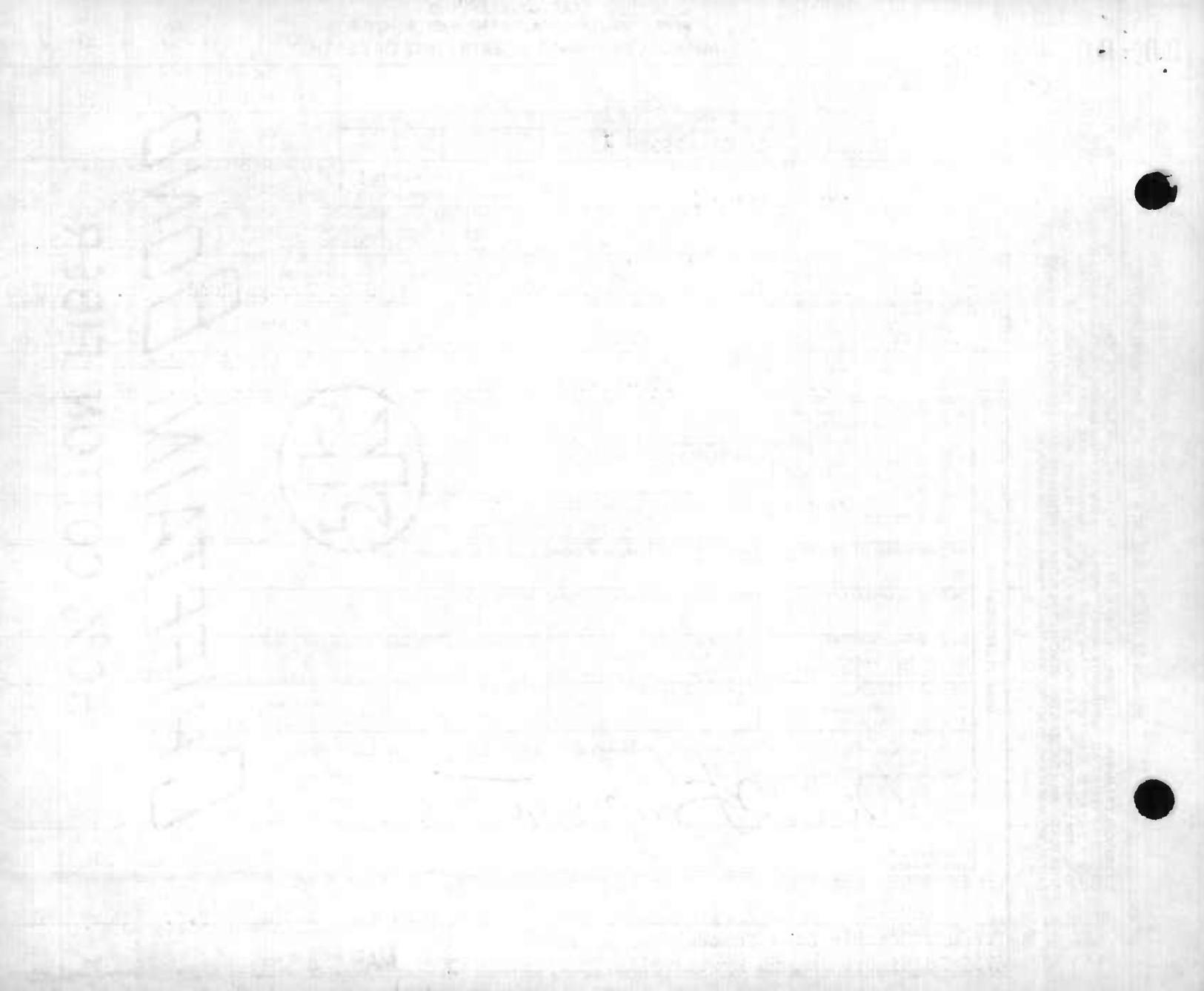
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1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH0 8 8 0 9  
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGES 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL CREATION, OR REMOVAL AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 DECEASED NAME (TYPE OR PRINT)		FIRST Robert	MIDDLE Edward	LAST Green	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 3-10	DAY 19	YEAR 86	2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH 10	DAY 01	YEAR 1932	6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD 3-10		7d. MONTH 19 YEAR 86 a.m.	
10. CITY OR TOWN OF DEATH College Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5002 Berwyn Road, Apt. 2				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Towing Co.	
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5002 Berwyn Road, Apt. #2 20740		
14. FATHER'S NAME FIRST Edward		MIDDLE 	LAST Green	15. MOTHER'S MAIDEN NAME FIRST Mary		16. ADDRESS 11645 Lockwood Drive Silver Spring Md		LAST Vermillion	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Charles H. Green (Brother)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1 DEATH WAS CAUSED BY:  <b>8902</b>          IMMEDIATE CAUSE (a) <b>Smoke Inhalation</b>          DUE TO, OR AS A CONSEQUENCE OF          Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.          (b) DUE TO, OR AS A CONSEQUENCE OF          (c)</p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:30 <input checked="" type="checkbox"/> 3-10 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject recovered from house fire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET 5002 Berwyn Rd., Apt. 2, College Pk., Prince		CITY OR TOWN COUNTY STATE			
<p>22a. I certify that I took charge of the remains described above, held on death resulted from Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion</p> <p>ACTUAL SIGNATURE  TITLE (SPECIFY) D. Assistant MEDICAL EXAMINER</p>									
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201		DATE SIGNED 3-10-86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3/13/86		23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN Cheltenham		COUNTY P.G.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 		STATE Maryland			
4739 Baltimore Avenue Hyattsville, Maryland 20781		MAR 14 1986							
BP _____		DHMH - 17 (VR A15 ME (5))							



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Then place in the burial permit. Then attach to the funeral director's permit. Then attach to the burial permit. Then attach to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certificate must be attached.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 6 0 8 8 1 0
					REG. NO.
1. DECEASED NAME <small>(TYPE OR PRINT)</small>		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR
Chester McKinley GREENE					March 25, 1986
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		2b HOUR
Male		White	Sept. 12, 1896		4:10p.m.
7a BIRTHPLACE <small>(STATE OR FOREIGN COUNTRY)</small>		7b CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Ohio		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	IF UNDER 1 YEAR MONTHS DAYS YRS
8. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Lanham		Doctors' Hospital of Pr. Geo. Co.		Prince George's MD.	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12b KIND OF BUSINESS OR INDUSTRY
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET ADDRESS / ZIP CODE	China Co.
Maryland	P.G.	New Carrollton		8221 Quentin Street 20784	
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	
Clarence			Greene	Lucy	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO OR UNKNOWN)</small>		16b SOCIAL SECURITY NO.		17. INFORMANT	
No		280-01-5219		Mrs. Dorothy M. Bolland New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					
<i>Carcinomatous metastatic from breast and arteriosclerosis Cardiovascular Disease</i> 5 years					
DUE TO OR AS A CONSEQUENCE OF 19. DUE TO OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED <small>(ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)</small>		
21d. INJURY OCCURRED <small>WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/></small>		21e PLACE OF INJURY <small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>	21f LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (1) this hospital attended the deceased from <u>March 13, 1986</u> , to <u>March 25, 1986</u> , (2) we last saw the deceased alive on <u>March 25, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did not view the body after death.)					
22b. SIGNATURE <i>William D. Rosson</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Rosson, M.D.					
22e. ADDRESS 5701 - 85th Ave., New Carrollton, Md. 20784					
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small>		23b. DATE Burial March 29, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Riverview Cemetery	23d. LOCATION CITY OR TOWN East Liverpool Columbian Ohio	23e. DATE REC'D. BY REGISTRAR APR 02 1986
24. FUNERAL DIRECTOR <small>NAME</small> F. Gasch's Sons F.H. P.A. Hyattsville, Maryland					
25b. REGISTRAR'S SIGNATURE <i>Jane Hudson Pendell</i>					

1965 Oct 20 1965 Oct 20

2. *Urtica dioica* L. (Urticaceae) - Common Nettle

910

• 10 - 1989

70 | TO

107 *Journal of Oral Rehabilitation* 1998

## NOTES ON

19. *Urtica dioica* L.

*discrepancy  
exists among them.*

2011 *Journal of Health Politics*

9201100000

The following are results of various tests. BIR-10-008

64

*woodwardi* (Woodward) S. L. Jones

but you will live to see it . . . .

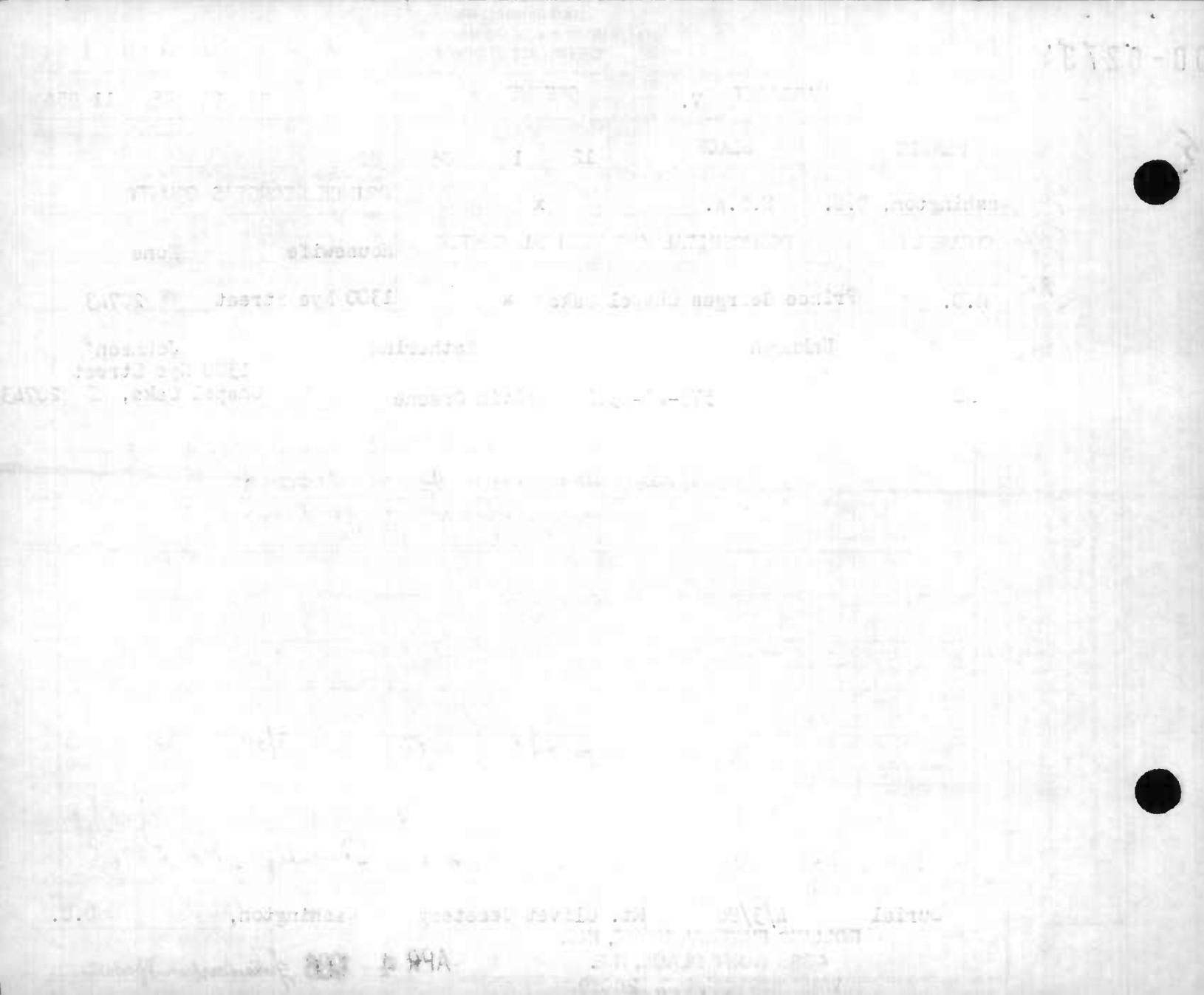
10 HOSPITAL OR ATTENDING PHYSICIAN: This line requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the original master carbon. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked 'No', item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8608811	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARGARET	MIDDLE V.	LAST GREENE	2a. DATE OF DEATH MONTH YEAR 03 29 86			MONTH DAY YEAR	2b. HOUR 11 05A <sub>M</sub>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH 12 DAY 1 YEAR 05			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS			IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY</b>			IF UNDER 24 HRS HOURS MIN.			
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>PGGHOSPITAL AND MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			MD.			
13a. STATE <b>M.D.</b>		13b. COUNTY <b>Prince Georges Chapel Oaks</b>		13c. CITY OR TOWN <b>Chapel Oaks</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>1300 Nye Street 20743</b>			
14. FATHER'S NAME FIRST Unknown		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST Katherine			MIDDLE			LAST Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>No</b>		<b>579-40-0382</b>		<b>Calvin Greene</b>			<b>1300 Nye Street Chapel Oaks, MD 20743</b>						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive lung disease</b>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (c) <b>Sepsis</b> , respiratory failure													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/18/86</b> to <b>3/19/86</b> , that (I) (we) last saw the deceased alive on <b>3/18/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <b>Pimolvarn Limpuangthip</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/30/86</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PIMOLVARN LIMPUANGTHIP</b>		22e. ADDRESS <b>P G &amp; H Cheverly, Md 20785</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/3/86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Washington,</b> COUNTY <b>D.C.</b>						
24. FUNERAL DIRECTOR NAME <b>ROLLINS FUNERAL HOME, INC.</b>		ADDRESS <b>4339 HUNT PLACE, N.E.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 4 1986</b>			25b. REGISTRAR'S SIGNATURE <b>Jeanne Davidson Pendleton</b>						
WASHINGON, D.C. 20019													



DATE: 10/10/00 BY: COOL

ПОДСИДЫ  
СЕЧКА СОСУДОВ

DATE: 10/10/00 BY: COOL

ПОДСИДЫ  
СЕЧКА СОСУДОВ

0-02263

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 6 0 8 8 1 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			John	D	Greenhorn Sr	MARCH 19, 1986			7 <sup>20</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male		White		July 30 1918		67 yrs.			MONTHS	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Washington DC		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George			GPO	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Forestville		7308 Mason Street		Bookbinder			U.S. Gov't			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE				
Maryland		Pr Geo		Forestville		7308 Mason Street 20747				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS			
		John		Greenhorn	Henrietta		Cuthbertson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes		WWII		579-09-1346		Patricia H Greenhorn			Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) attended the deceased from June 19 82 to March 19 86, that (I) (we) last saw the deceased alive on Feb 21 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John N. Van Dam M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/19/86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		412 1st Street SE Washington DC						
John Van Dam, M.D.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		22 Mar 1986		Epiphany Epis. Cemetery		Forestville		Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		DATE OF BURIAL		25. REGISTRAR'S SIGNATURE				
Robert E. Wilhelm Funeral Home		Suitland, Md.		Mar 19 1986						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached by him on the burial permit. Then please return carbon papers. Page 1 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or **NO**, it means any injury or other traumatic event, the medical attendant should sign page 4.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	0	8	1	3		
										REG. NO.							
1. FOR STATE REGISTRAR			LAST NAME JOSEPH      Bernard      GULLI			2d DATE OF DEATH 03-18-86			2b HOUR 1 : 34PM								
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			2d MONTH YEAR			2b DAY								
3. SEX <b>Male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>March 22, 1912</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS								
7a. BIRTHPLACE COUNTRY <b>Washington, D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b>								
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Washington Post Newspaper</b>								
13a. STATE <b>Maryland</b>			13b. COUNTY <b>P.G.</b>			13c. CITY OR TOWN <b>Cheverly</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>5724 Lockwood Road 20785</b>					
14. FATHER'S NAME FIRST <b>Joseph</b>			MIDDLE <b>Bernard</b>			LAST <b>Gulli</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b>			MIDDLE <b>E.</b>			LAST <b>Nolan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes-Navy</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II</b>			17. INFORMANT <b>Mrs. Thelma V. Gulli</b>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			ADDRESS <b>Address Same as No# 13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for item 18a and c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central edema</b>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular thrombosis with infarction</b>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic cerebrovascular disease</b>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>diabetes mellitus &amp; atherosclerotic heart disease</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from <b>1980</b> , 19_____, to <b>MARCH 18 86</b> , that (1) (we) last saw the deceased alive on <b>3-19 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body prior to death.																	
22b. SIGNATURE <i>James W. Harding, M.D.</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>3/18/86</b>								
22f. PHYSICIAN'S NAME, TYPE OR PRINT <b>James W. Harding, M.D.</b>			22g. ADDRESS <b>6005 Landover Rd. Cheverly, Maryland</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>March 21, 1986</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cem.</b>			23d. LOCATION CITY OR TOWN <b>Silver Spring</b>			COUNTY <b>Montgomery</b>					
24. FUNERAL DIRECTOR <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1986</b>			25b. REGISTRAR'S SIGNATURE <i>Julia Townsend Pendell</i>								

1000

201 students  
returning

morning

The 1990 French Budget Act

1995-1996

• *“I am not a man of words, but I am a man of action.”*

*Business improved to record 7000 in 1997, with 1998 showing signs of recovery.*

Surfacing of the bottom of the lake.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

rejoined by the hospital or attending physician.  
 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper, sign with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 18 shows any injury, or other traumatic event, check here \_\_\_\_\_

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608814			
1 - STATE REGISTRAR <i>BP</i>		1. DECEASED NAME AKA FIRST Lucille MIDDLE James LAST Haas Alice Lucille Haas					2a DATE OF DEATH MONTH DAY YEAR <i>3-18-86</i>		2b HOUR <i>10 AM</i>				
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 22, 1927</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>		MD.				
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Contee Sand &amp; Gravel</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Beltsville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>12027 Old Gunpowder Rd. 20705</b>				
14. FATHER'S NAME FIRST <b>Willie</b>		MIDDLE <b></b>		LAST <b>James</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ethel</b>		MIDDLE <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>229-28-4656</b>		17. INFORMANT SPOUSE ADDRESS <b>Emil I. Haas, Sr. Same as Line #13</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Exacerbation Obstructive Lung Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>3-18-86</i> , to <i>3-18-86</i> , that (I) (we) last saw the deceased alive on <i>3-18-86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.										22c. DATE SIGNED <i>3/18/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W.A. Warren</i>		22e. ADDRESS <i>301 Alpine Corp St Laurel MD 20708</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-22-86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Brentwood, P.G., Maryland</b>						
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>										25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Sister Davidson Pendleton</i>	
DHMH - 16 60M 7/B4 (VRA 15, 4)													

May 10-10

video player coming

most efficient front end

found

front end

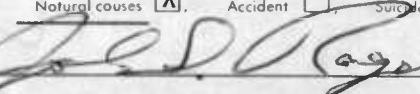
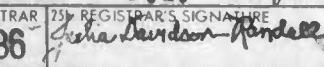
well put together

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functionality and auto-align

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03815					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN OF ESTI- DEATH MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b HOUR
George			Elmer						Hagstrom			3/18		1986	A.	10:45	
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR.	8 IF UNDER 24 HRS.	9 MONTH	DAY	YEAR	10:45								
Male	White	Aug. 31, 1897	88 yrs.	MONTHS	DAYS	HOURS	MIN.										
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Illinois		U.S.A.								Prince George's County MD.							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
College Park			8409 Patuxent Avenue						Supervisor			U.S. Dept. of Commerce					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS									
Maryland		Prince George's		College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8409 Patuxent Avenue 20740									
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
George			V.			Abbott			Lizzie			E.			Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Address Same as					
No			334-07-1309			Mr. Richard W. Hagstrom			No# 13.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>																	
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
None																	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			None								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 															TITLE (SPECIFY) Deputy MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.															DATE SIGNED 3/18/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial March 22, 1986			23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood			COUNTY STATE P.G. Maryland					
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. ADDRESS Hyattsville, Maryland															25a. DATE REC'D. BY REGISTRAR MAR 24 1986		
															25b. REGISTRAR'S SIGNATURE 		

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U.S. Department of Commerce

• If no contract, begin at 100% -

but can tell them what to do? Please?

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.

ITEM 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08816		
												REG. NO.		
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI- DEATH MATED			2b HOUR		
			<i>Lawrence Augustus HALL</i>						3-5 1986			M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD MONTH DAY YEAR		
Male		Black		FEB 2, 1924		62						3-5 1986		
7d BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7e CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			United States									Prince Georges		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Cheverly			<i>Prince George's General Hospital</i>			truck driver			Transportation					
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
MD			Wash., D.C.			YES <input checked="" type="checkbox"/>			142 Kentucky Avenue, S.E.					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
RALPH HALL			VIOLA MITCHELL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			577 20 8233A			Margaret Hall-wife-142 Ky Ave., S.E. DC								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Prosthetic arteria pulmonis embolized cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20d AUTOPSY?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED <i>3-5-86</i>					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn Ct., Temple Hills, MD								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn Ct., Temple Hills, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN					
Burial			Mar 11, 1986			Lincoln Memorial Cemetery Suitland			COUNTY PG STATE Maryland					
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
ALEXANDER S. POPE 2617 Pa Ave SE Wash DC						MAR 18 1986			<i>John Davidson - Rodriguez</i>					
DHMH-17 (VR A15 ME (5))														

C1801-00

00-01261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use in the burial/transit permit. Then please return certificate, Page 1 and 2 should be held within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked  Name 18 (Cause of Death) is marked 

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08817			
1. DECEASED NAME (TYPE IN PRINT)				MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
SAMUEL						HALL		March 15, 1986		7:13 A.M.			
35		3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS			
34		Male		Black		Sept. 10, 1915		70 yrs		IF UNDER 24 HRS HOURS MIN.			
35		7. BIRTHPLACE STATE OR FOREIGN COUNTRY		8. CITIZEN OF WHAT COUNTRY?		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION SECURITY Patrol Agrie. Dept.	
34		MD		U.S.A.				Prince George's MD.		12b. KIND OF BUSINESS OR INDUSTRY			
35		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9920 Harmony Lane / 20707			
30		Md.		Howard		Laurel							
21		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
21		Rudolphus Hall		Nora Briggs									
18		16a. DECEASED EVER IN U.S. ARMED FORCES? NO. OR UNKNOWN		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 minutes			
21		(U.S. WAR ORATES) WWII						SUDDEN CARDIAC ARREST					
21		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost		(b) POSSIBLE ACUTE Myocardial Infarction		DUE TO, OR AS A CONSEQUENCE OF							
21		{		(c) ATHEROSCLEROTIC CORONARY ARTERY DISEASE		DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Kevin D. Muller</i>		22c. DEGREE MB - ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 1986									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kevin D. Muller</i>		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3-21-86		23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery		23d. LOCATION CITY OR TOWN Jessup, Howard, MD		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME		24b. DATE George R. Snowden 246 N. Washington St. Rockville, MD 20851 3-21-1986		24c. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Guiderdon-Snowden</i>							
BP													
DHMH - 16 60M 7/B4 (VRA 15, 4)													

11820

11820-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												08318			
												REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR		
15			NICHOLAS JOSEPH HANYOK						March 8, 1986				4:15 p.m.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White			Month Day Year			29x 28			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			USA									Prince George's County MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR PRINT)			12b. KIND OF BUSINESS OR INDUSTRY						
Lanham			AMI/Doctors' Hosp. of Pr. Geo. Co.			N/A Handicapped									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland			13b. COUNTY Prince George			13c. CITY OR TOWN Greenbelt			13e. STREET ADDRESS / ZIP CODE 241 Lastner Lane 20770			13f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min			
14. FATHER'S NAME			MIDDLE			15. MOTHER'S MAIDEN NAME									
Stephen			Hanyok			Angela Anne						Burskey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			216-68-0009			Stephen Hanyok Same as #13									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 28 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <i>cardiac arrest</i>															
(c) <i>decreased pulmonary &amp; heart function</i>															
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF															
<i>traumatic force became vertebral artery difficult to</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED P.M. 19			21d. LOCATION STREET CITY OR TOWN COUNTY STATE						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)												
22a. I certify that (I) (this hospital) attended the deceased from <i>never</i> 1965 to <i>Mar 8 86</i> , that (I) (we) lost saw the deceased alive on <i>Mar 8 86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED <i>3-8-86</i>			
22b. SIGNATURE <i>The Bergemann</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Till Bergemann M.D.</i>			22e. ADDRESS <i>115 Centerway, Greenbelt, Md. 20770</i>												
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3-12-86			23c. NAME OF CEMETERY OR CREMATORIUM Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton COUNTY Prince George STATE Md.						
24. FUNERAL DIRECTOR Donald V. Borgwardt			4400 Powder Mill Rd Beltsville Md 20705			25a. DATE REC'D. BY REGISTRAR MAR 14 1986			25b. REGISTRAR'S SIGNATURE <i>Donald Borgwardt</i>						
BP															
DHMH - 16 60M 7/B4 (VRA 15, 4)															

2600-00



072135  
John Hartnett - wants copy

TO HOSPITAL OR ENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as a transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 3608819											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
OLGA E. HARTNETT						MAR 2, 86				5:39 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
F		W		Aug 14 1910		75					
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Washington DC		USA				Prince George's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR WHICH WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		20746			
Clinton		Southern Maryland Hospital		Inspector		Film Industry					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13b. STATE Maryland		13c. COUNTY Pr Geo		13d. CITY OR TOWN Suitland		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS, ZIP CODE 2514 Lewis Avenue			
14. FATHER'S NAME FIRST Charles		MIDDLE		LAST Jones		15. MOTHER'S MAIDEN NAME Emma V		16. ADDRESS Oxon Hill Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH AND DEATH					
NO		577 24 9045		Daniel C Hartnett		833 Shelby Dr 20745				1-2 hrs	
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 18. REVERSIBLE SHOCK											
DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE ABDOMINAL HEMORRHAGE 2-3 days											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED ABDOMINAL AORTIC ANEURYSM -											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION 3.2.86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SAME AS ABOVE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3.2.86 to 19.86, that (I) (we) last saw the deceased alive on 3.2.86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael G. Seremetis, MD		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3.2.86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL G. SEREMETIS, MD		22f. ADDRESS 3921 FERRARA DR - SILVER SPRING MD 20906									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4 March 86		23c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet Cemetery		23d. LOCATION CITY OR TOWN Washington		COUNTY		STATE D.C.	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home ADDRESS Suitland Maryland		25a. DATE REC'D. BY REGISTRAR MAR 06 1986		25b. REGISTRAR'S SIGNATURE John Kindred Pendleton							



00-02322

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. B 6 0 8 8 2 0

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Emily A. HAWKINS						3 JUNE	27	86		2:45AM	
3a SEX	3b RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
F	W	JUNE 28, 1909			76	YRS					
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH RENTICE BEAUREGE MD.			
N.C.		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
HAWTHORNE		CARROLL MANOR			Housewife			Own Home			
13. RESIDENCE (IF HOSPITAL OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS ZIP CODE		
13a STATE MARYLAND		13b COUNTY Renice Beause		13c CITY OR TOWN Hawthorne					4922 LASALLE ROAD		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			LAST		
JONATHAN				Willis		Doeis			EDWARDS		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No		228-10-6326			ATTORNEY - Arthur Carton			1225-19th St. Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						MYOCARDIAL INFARCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
{ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						{ DUE TO, OR AS A CONSEQUENCE OF b) HYPERTENSIVE ART. Scl. CAR. REN VAS DIS			1 Hour		
{ DUE TO, OR AS A CONSEQUENCE OF c)									YEARS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19b.							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21a.		21b.			21c.						
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		3/26/86			19 79			to 3/26/86, that (I) (last above, (I) <input type="checkbox"/> did not view the body after death,			
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED			
Frederick W. Schneider MD											3/26/86
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS									
Frederick W. Schneider		5401 MACARTHUR BLVD NW DC 20016									
23a. BURIAL, CREMATION, REMOVAL CUSTODY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. DATE CERTIFIED BY REGISTRAR			23f. REGISTRAR'S SIGNATURE
Burial		3-31-86		Estate of Heaven Cemetery		Silver Spring, Mo					John D. Johnson
24. FUNERAL DIRECTOR		24b. FUNERAL HOME			24c. DATE			24d. FUNERAL HOME			APR 02 1986
James D. Johnson		WASH. D.C.			APR 02 1986			WASH. D.C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (See § 18-4 of the Health General Law.)

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then place removal certificate (Pages 1 and 2) and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18, (a) any injury or other traumatic event, the medical examiner must be called at once.

Required by the Hospital as attending physician.

BP \_\_\_\_\_

DHMH - 16 60M 7/84

(VRA 15, 4)

SES 0-0



066225

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 8 2 1

REG. NO.

1. DECEDENT'S NAME (TYPE OR PRINT)				FIRST <b>Elsie</b>	MIDDLE <b>Mary</b>	LAST <b>HEALY</b>	2a. DATE OF DEATH MONTH <b>August</b>	DAY <b>4</b>	YEAR <b>1888</b>	2b. HOUR 5:45p.m.			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>August</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>District of Columbia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b>						
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home, Inc.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince-Georges</b>		13c. CITY OR TOWN <b>Takoma Pk.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>706 Bayfield Street 20912</b>			
14. FATHER'S NAME FIRST <b>Noah</b>				MIDDLE <b>John</b>	LAST <b>Zeller</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Fanny</b>			MIDDLE	LAST <b>Hammer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-26-3096</b>		17. INFORMANT <b>WILLIAM C. HEALY, 706 Bayfield St. Tak. Pk.</b>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last (b) _____ (c) _____  DUE TO, OR AS A CONSEQUENCE OF <b>Carcinoma of the Breast 2 years</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Arteriosclerotic Heart disease, Dementia</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>2/6/86</b> to <b>7/21/86</b> , that (I) (we) last saw the deceased alive on <b>2/6/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Ibrahim M. Khatari</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>MARCH 1, 1986</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IBRAHIM M. KHATARI</b>		22e. ADDRESS <b>6525 Belcrest Rd #902 Hyattsville MD</b>											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial.</b>		23b. DATE <b>MARCH 4, 1986</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN <b>Silver Spring, MONTGOMERY MD.</b>						
24. FUNERAL DIRECTOR <i>Albert Walters</i>		254 Carroll St. N.W. Takoma Funeral Home.		25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1986</b>			25b. REGISTRAR'S SIGNATURE <i>J. G. Henderson</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified in writing.

over 1 month      young      adult      old  
    vs      0001 - young      adult      older  
several species      x      ADO      difficult to separate  
                       small adult small boxes      difficult  
several species vs      x      off season      very young      basal part  
                       several      small      trifoliate      adult      dead

A

All 5-2000 meters & well developed

May 21st 1968

several small, dark brown structures

all like

as last

the

greenish

shorter & with less hair than the others

different

very thin &...

thin leaf